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AN INVESTIGATION INTO AIDS PREVENTION IN THE WORKPLACE - GUIDELINES TO A SOCIAL MARKETING WORKPLACE PREVENTATIVE AIDS STRATEGY

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ABSTRACT

AIDS - the Acquired Immune Deficiency Syndrome - is an unprecedented health problem facing the entire world. It is a disease caused by the Human Immuno-deficiency Virus (HIV) which takes an average of ten years to develop into full-blown AIDS. During this time, a person with HIV may lead a productive life. AIDS however, is usually terminal. There is no cure in sight, and no vaccine is likely for several years. At present, health education is the best known means to AIDS prevention.

AIDS is not only a medical issue: It has social, political, religious, economic, financial, legal and ethical implications too. AIDS in the workplace is a vital cog in the AIDS pandemic wheel and its potential impact on the workplace is immeasurable: Employees fall into the reproductive age group and are therefore vulnerable to AIDS. This in turn adversely affects business in terms of loss of skilled manpower, decreased productivity, workplace disruption, higher health care and employee benefits costs... **It is therefore both in the interests of the employers and employees to take advantage of the organisational structure and undertake preventative AIDS efforts in the workplace.**

Social Marketing is concerned with the goals of business and society. It is involved with matters of social concern - it is the marketing of social causes or programmes designed according to the current identified and latent needs and wants of the target market(s).

This dissertation comprises an application of social marketing principles and techniques to AIDS prevention in the workplace.

The overall research objective of this dissertation is to investigate the provisions which have been made for AIDS in companies in South Africa, and to gain an understanding of the "preventative AIDS provisions" which the respondents consider practical to implement in their workplace, in order to generate conclusions and recommendations. The research findings, discussions and conclusions highlight areas for future research.

The dissertation begins with a detailed description of the primary problem and overall research objective of the study. This is followed by a comprehensive review of the literature on social marketing which provides a sound theoretical base.

A two-stage research approach which can be categorised as being along the exploratory - descriptive research continuum was adopted. The initial stage involved informal research which was followed by a quantitative study comprising of mail questionnaires which were sent to companies in the sample throughout South Africa.

The findings and discussions to the investigation into the preventative AIDS efforts of the companies in the sample provide an understanding of **what** some South African companies have done with respect to AIDS prevention in the workplace, and **how** they have gone about it. The findings **supported** the two main hypotheses - The majority of the companies do not have a formal AIDS policy, nor ongoing AIDS education for management and employees.

The respondents from the companies have given a clear signal that they are willing to further preventative AIDS efforts in their workplace.

The **current** preventative AIDS actions by the companies, and what the respondents state they are **prepared** to do, highlight **areas for future research.**

The research findings and discussions to the preventative AIDS provisions which the respondents from the companies consider **practical** to implement in their workplace show that the main hypothesis is **not supported** by the findings - the respondents **do** consider it practical to undertake preventative AIDS provisions (policy and education) in their workplace. **The challenge is to seize this opportunity, and develop a strategy aimed at facilitating the adoption of practical preventative AIDS provisions by companies throughout South Africa.** This challenge is complicated by the respondents' overall lack of agreement with respect to an AIDS policy approach, and is simplified by the "majority practical response" to a thorough preventative AIDS education programme.

From the research findings and discussions arduous challenges have been identified. The solution does not lie simply in recognising these challenges. There is a need for action. Evidence from the literature suggest that social marketing principles and techniques are compatible with the task of AIDS prevention in the Workplace. **It is therefore proposed that a solution to the identified challenges is a Workplace Social Marketing Preventative AIDS Programme.**

DECLARATION

I declare that this dissertation is my own unaided work. It is being submitted for the degree of Master of Business Science at the University of Cape Town. It has not been submitted before for any degree or examination at any other university.

TRACEY PIKHOLZ
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GLOSSARY

AIDS — An abbreviation for Acquired Immune Deficiency Syndrome

HIV — An abbreviation for Human Immuno-deficiency Virus. HIV destroys the body's immune defence system

HIV-positive — The infection with HIV stimulates the production of HIV-antibodies. These are ineffective in neutralising the virus itself and merely act as an indicator of the presence of HIV.

Preventative AIDS Provisions/Efforts — The efforts in which an organisation has engaged in order to combat AIDS (eg: AIDS policies, preventative AIDS education)

Formal AIDS Policy — An AIDS policy which is formalised in writing

Organised Preventative AIDS Education — AIDS education which is ongoing or once-off.

WHO & ILO — World Health Organisation and International Labour Organisation

CHAPTER ONE

INTRODUCTION AND PROBLEM DEFINITION

1.1 Background

AIDS - the Acquired Immune Deficiency Syndrome - is an unprecedented health problem facing the entire world. AIDS is not only a medical issue: It has social, political, religious, economic, financial, legal and ethical implications too.

AIDS in the workplace is a vital cog in the AIDS pandemic wheel and its potential impact on the workplace is immeasurable: Employees fall into the reproductive age group and are therefore vulnerable to AIDS. This in turn adversely affects business in terms of loss of skilled manpower, decreased productivity, workplace disruption, higher health care and employee benefits costs... It is therefore both in the interests of the employers and employees to take advantage of the organisational structure and undertake preventative AIDS efforts in the workplace.

This dissertation comprises an application of social marketing principles and techniques to AIDS prevention in the workplace. Social Marketing is concerned with the goals of business and society. It is involved with matters of social concern - it is the marketing of social causes or programmes designed according to the current identified and latent needs and wants of the target market(s).

In this dissertation, the approach of South African companies towards AIDS in the workplace is analysed against a background of external social marketing, (marketing which serves not only the needs of business but the goals of society too, its contribution extends beyond the formal boundaries of the firm). The **implications** of adopting and using the tools of social marketing with respect to an internal workplace social marketing AIDS programme, (the relationship between an organisation and its employees) are discussed.

While the literature on social marketing encompasses studies on preventative health services, such as family planning, there is no evidence of a **workplace** social marketing preventative AIDS programme.

This study is of an exploratory, descriptive and prescriptive nature.

1.2 Defining the Problem

The general problem statement (the primary problem under consideration) can be stated as: An investigation into the provisions which have been made for AIDS in companies throughout South Africa, and what "preventative AIDS provisions" the respondents from the companies consider **practical** to implement in their workplace. Central to this is the policy approach of the companies in the sample regarding AIDS prevention in the workplace, as well as their preventative AIDS education efforts.

Integral to this problem are a number of secondary problems that need to be identified and solved in order to generate conclusions and recommendations to the primary problem.

They include:

a. Recruitment and selection policies for applicants with HIV
b. Procedures regarding employees who have HIV
c. The type of preventative AIDS education
d. The perceived impact that AIDS will have on the companies
e. The level of AIDS awareness, and
f. The willingness of the respondents from the companies to further their AIDS efforts, both internally and externally.

1.3 The Objectives of the Study

1.3.1 The Overall Research Objective

The **overall research objective** of this study is two-fold:

To investigate and gain an understanding of

(i) The **provisions** which have been made for AIDS in the companies in the sample
(ii) The "preventative AIDS provisions" which the respondents from the companies in the sample consider **practical** to implement in their workplace

in order to recommend **practical** guidelines for a workplace social marketing preventative AIDS programme.

The overall research objective has been divided into main objectives and sub objectives. Owing to the dual nature of the overall research objective, sections 1.3.2 and 1.3.3 discuss the main and sub objectives pertaining to (i) above. Sections 1.3.4 and 1.3.5 discuss the main and sub objectives pertaining to (ii) above.

1.3.2 Main Objectives and Null Hypotheses

(See 1.3.1 (i))

The main objectives relate to the primary problem: An investigation into the provisions which have been made for AIDS in companies throughout South Africa. (1.2). Since this study is of an exploratory nature, the hypotheses are not rigorously tested. Rather the research findings will be examined as to whether the hypotheses are supported or not. (Null hypotheses are statements that will be accepted until overwhelming contradictory information is produced. Typically they are phrased in negative, sceptical terms but can be firm, positive statements as well. (Weiers: 1984))

1) Objective: To establish whether the companies have **formal AIDS policies.**

$H_{o(1)}^{(A)}$: **The majority of the companies do not have a formal AIDS policy.**

2) Objective: To establish the volume of **preventative AIDS education** undertaken by the companies.

$H_{o(2)}^{(A)}$: **The majority of the companies do not have ongoing AIDS education for management and employees.**

1.3.3 Sub Objectives and Null Hypotheses

The sub objectives and hypotheses relate to the secondary problems (1.2). They need to be investigated in order to generate conclusions to the main objectives and hypotheses, and thus the primary problem.

1) Sub Objective: To determine whether AIDS has influenced **recruitment and selection** policies.

   $H_{o(1)}^{(B)}$: **AIDS has had no influence on recruitment and selection policies.**

2) Sub Objective: To establish whether an HIV-positive employee will be permitted to **continue working as before.**

   $H_{o(2)}^{(B)}$ **An HIV-positive employee will not be permitted to continue working as before.**

3) Sub Objective: To establish whether AIDS is expected **to affect the companies.**

   $H_{o(3)}^{(B)}$: **AIDS is not expected to have an impact on the companies.**

4) Sub Objective: To establish whether management and employees have the same level of **AIDS awareness.**

   $H_{o(4)}^{(B)}$: **Management and employees do not have the same level of AIDS awareness.**

5) Sub Objective: To determine whether the respondents from the companies are willing to devote (additional) resources to **AIDS prevention internally.**

   $H_{o(5)}^{(B)}$: **The respondents from the companies are not willing to devote (additional) resources to AIDS prevention internally.**

1.3.4 Main Objective and Null Hypothesis

(see 1.3.1 (ii))

The main objective relates to the primary problem (1.2) under consideration - what "preventative AIDS provisions the respondents from the companies consider practical to implement in their workplace".

1) Objective: To establish whether the respondents from the companies consider it practical to undertake **preventative AIDS provisions** (policy and education) in their workplace.

$H_{o(1)}^{(A)}$: **The respondents from the companies consider it impractical to undertake preventative AIDS provisions (policy and education) in their workplace.**

1.3.5 Sub Objectives and Null Hypotheses

The sub objectives and hypotheses relate to the secondary problems (1.2 a,b,c). They need to be investigated in order to generate conclusions to the main objective and hypothesis, and thus the primary problem.

1) Sub Objective: To determine whether the respondents from the companies are all in agreement with respect to their approach towards HIV-related **pre-employment** issues.

$H_{o(1)}^{(B)}$: **The respondents from the companies are not all in agreement with respect to their overall approach to HIV pre-employment issues.**

2) Sub Objective: To establish whether the respondents from the companies all agree with respect to HIV-related issues **during employment.**

(B)
$H_{o(2)}$: The respondents from the companies do not all agree with respect to their approach towards HIV-related issues during employment.

3) Objective: To determine whether the respondents from the companies consider a **thorough preventative AIDS education** programme practical to implement in their workplace.

(B)
$H_{o(3)}$: The respondents from the companies do not consider a thorough preventative AIDS education programme practical to implement in their workplace.

1.4 Implications of this Research

To date (1991), in South Africa, there appears to have been no empirical research into: The preventative AIDS provisions which companies have undertaken in the workplace, what the respondents consider practical to implement with respect to AIDS, and based on the results of the study, the application of social marketing techniques to **practical guiding principles** for a Workplace AIDS Prevention Programme.

While a number of articles on issues concerning AIDS in the workplace have been written, practical guidelines based on empirical research are still largely undocumented. Furthermore, no **social marketing** preventative AIDS programme in the **workplace**, appears to have thus far been conducted. This report aims to make a contribution to the current dearth of knowledge in this sphere.

It is believed that this research will provide: insight into how South African companies have approached the challenges which AIDS presents to them, and an understanding of what AIDS-related provisions the respondents from the companies consider practical to implement in their workplace. Additionally, the recommendations which follow will facilitate the development of a **social marketing strategy** for the internal management of AIDS and related workplace issues, as well as strengthening the "social contract" between an organisation and its publics.

More specifically, it can then be determined how best to ensure the **well-being of the company and employees** in terms of maximising productivity, minimising workplace disruption and discrimination, as well as promoting the adoption of preventative AIDS behaviour. This in turn will contribute to the **economic and social well-being of society** as a whole - which is the essence of social marketing programmes.

1.5 Scope and Limitations

Firstly, the approach is largely investigatory, therefore the hypotheses are not rigorously proved or disproved. (Rather, they are substantiated or not substantiated by the findings.) Secondly, this study concentrates on AIDS and the Workplace, and not the medical aspects of the disease. Thirdly, the ultimate aim of this study is to provide insight into the **management of AIDS in the workplace**, and **not** to provide guidelines to general AIDS education programmes which promote the adoption of preventative AIDS behaviour. Such education programmes demand the expertise of counsellors and education specialists, which falls outside the domain of this study.

1.6 How the Dissertation is Organised

The study comprises nine chapters:

Chapter 1 has presented a brief background to the research, the research objectives and hypotheses, as well as the implications, scope and limitations of this study.

The next three chapters cover the literature review that was conducted into social marketing. Chapter 2 deals with the origins of social marketing, and discusses this multifaceted social marketing concept. Contrasting opinions are discussed, and a definition of social marketing proposed.

In chapter 3 social marketing and preventative health services are discussed. This provides an understanding of how social marketing can be successfully applied to health promotion such as family planning, and suggests that an awareness of the ethical dilemmas in preventative health care is critical.

Chapter 4 demonstrates that AIDS and its impact on the workplace is a just cause for social marketing. Based on the viewpoints of experts in the field, the impact of AIDS, challenges facing an AIDS education programme, as well as AIDS-related workplace issues are discussed.

Chapter 5 describes the research methodology undertaken.

The analysis, discussion, and conclusions to the first part of the overall research objective (1.3.1(i)), are covered in chapter 6. The "status quo" of workplace AIDS efforts in South Africa is described.

Chapter 7 is concerned with the findings, interpretations and conclusions to the second part of the overall research objective (1.3.1(ii)). Insight into the preventative AIDS efforts which the respondents from the companies consider practical and impractical to implement in their workplace, is provided.

Chapter 8 discusses the critical research findings which have emerged from the study, and which form the foundation of the recommendations which follow.

The findings and conclusions arising from the entire study provide input into the social marketing recommendations which are covered in the final chapter.

1.7 Summary

In order to achieve the overall research objective, the research findings will be carefully analysed in terms of the main objectives and hypotheses, and sub objectives and hypotheses. The discussions, conclusions and recommendations will then follow.

However, in order to provide a unified, theoretical foundation, a literature review of the social marketing concept is first discussed.

CHAPTER TWO

THE SOCIAL MARKETING CONCEPT

2.1 Introduction

This chapter is the first of three covering the literature review conducted for this dissertation.

The **purpose of this literature review** is to:

- Clarify and consolidate the core issues and facts surrounding the **Social Marketing Concept**
- Discuss the scope for the application of **Social Marketing Techniques to Preventative Health Services**, and
- Provide a background on the implications of AIDS and show how **Workplace Preventative AIDS Efforts** are a **just cause for social marketing.**

The aim of chapter 2 is firstly, to discuss the **Origins of Social Marketing** (2.2), and secondly, to provide a review of **The Social Marketing Concept** (2.3). The latter includes: Definitions (2.3.1), Types and Processes of Social Change (2.3.2), The Social Marketing Process (2.3.3), Required Conditions for Effective Social Marketing (2.3.4), and Criticisms of this "Broadened" Approach to Marketing (2.3.5). Finally, Social Marketing and Social Responsibility - a South African Evaluation is briefly discussed (2.3.6).

2.2 Origins of Social Marketing

In this section the origins and recent history of social marketing is traced.

The continued health and in fact survival of a discipline depends on its ability and willingness to re-examine its scope and parameters constantly in the light of dynamic changing environments, and to adapt accordingly.

In the past, (and to a certain extent today), marketing was seen as purely a business activity, that is, processes and activities that ultimately result in a 'market transaction'. (Luck: 1969)

In 1969, Kotler and Levy first proposed their broadened perspective of marketing. Here they describe marketing as a pervasive societal activity which goes beyond 'the ultimate purchase and sale of a product or service'. (Luck: 1969) They realised, that the fact that effective marketing requires a consumer orientation as opposed to a product orientation, rather than restricting marketing to business activities, actually extends its horizons: 'The choice facing those who manage non-business organisations is not whether to market or not to market, for no organisation can avoid marketing. The choice is whether to do it well or poorly ... ' (Kotler and Levy: 1969) That is, **marketing is applicable to all areas where an organisation attempts to relate to its customers and other publics too.**

Lazer (1969) recognised that marketing should share in the problems and goals of society and its contributions should extend well beyond the formal boundaries of the

firm. This can be interpreted as "**external** social marketing". He called for a definition of marketing that recognised the discipline's expanding societal dimensions:

> 'Marketing is not an end in itself. It is not the exclusive province of business management. Marketing must serve not only business but also the goals of society. It must act in concert with broad public interest. For marketing does not end with the buy-sell transaction - its responsibilities extend well beyond making profits. ' (Lazer: 1969)

Despite the fact that Kotler, Levy, and Lazer extended the marketing concept, Kotler argues that this broadening proposal did not go far enough. He thus broadened this proposal still further to include a generic concept of marketing, which became the foundation of a generally accepted definition of marketing:

> 'Marketing is a human activity directed at satisfying needs and wants through **exchange** processes.' (Kotler: 1984)

This definition incorporates the issue of "**exchange**".

> 'Exchange: the act of obtaining the desired resources by offering something in return. Marketing arises from this approach. Most organisations acquire their resources through engaging in mutually beneficial exchanges with others. Organisations offer satisfaction, in the form of goods, services or benefits, to markets and receive needed resources (goods, services, time and energy) in return.' (Kotler: 1982,1984)

Five conditions must be satisfied for exchange to take place: (Kotler: 1982,1984):

- there must be at least two parties
- each party has something to offer that the other party perceives to be of value
- each party is capable of communication and delivery
- each party is free to accept or reject the offer

Therefore, Kotler sees exchange as a process in which two parties engage, in order to reach an agreement and hence a transaction. 'A transaction is the exchange of values between two parties.' (Kotler: 1975). Examples of exchange processes include between seller and buyer (goods or services are exchanged for money), and between employer and employee (wages and fringe benefits are exchanged for productive services). (Kotler: 1984)

However, 'exchange' is a contentious issue:

> 'Is social welfare consonant with the bilateral transfer characteristics of an exchange or market economy, or can it be realised only through the unilateral transfer of a grants economy?' (Lazer: 1969)

It is generally accepted that the concept of exchange extends to any giving and taking whatever the nature of the parties involved and whatever type of commodity is being exchanged. The question of whether the 'broadened concept of marketing' is an exchange process is both a fundamental and controversial issue. That is, its compatibility with marketing as an exchange process determines both its credibility and validity.

The broadened concept of marketing or social marketing, certainly does involve the concept of exchange: In taking an action, or adopting a behaviour, an opportunity cost is involved, that is, the individual is giving up something. The marketer, realising this, attempts to increase the expected benefits of this opportunity cost, that is, the marketer attempts to increase the person's perceived rate of exchange.

Therefore, the concept of marketing is the beneficial exchange between an organisation and its target markets 'for the purpose of achieving organisational objectives'. (Kotler: 1984) 'Exchange = marketing' and 'marketing = exchange' (Foxall: 1984).

Since 'the scope of marketing is unquestionably broad', (Hunt: 1976) and marketing is a human activity directed at satisfying needs and wants through exchange processes - there is no reason why the marketing of social ideas and causes should not assume as much importance as the marketing of physical products.

2.3 The Social Marketing Concept

2.3.1 Definitions

> '(Social Marketing is) the design, implementation, and control of programmes calculated to influence the acceptability of social ideas and involving considerations of product, pricing, communications and marketing research.' (Fox and Kotler: 1980)

Therefore, social marketing was conceived to be an application of marketing concepts and techniques to the marketing of various socially beneficial causes in order to elicit desired audience responses.

Thomas argues that Fox and Kotler reveal their own confusion in the above definition. That is, since Kotler himself defines marketing as 'a human activity directed at satisfying needs and wants through "exchange processes"', and since no concept of exchange is involved in the above definition, Thomas holds that they are not talking about marketing as a process. This in fact threatens the very existence and credibility of social marketing. In order to prevent this, Thomas distinguishes between marketing as a

concept, and marketing techniques seen as transferable skills, which can be applied to many environments, some of which are remote from the concept of exchange. Hence, he proposes the following definitions: (Thomas: 1983)

1. Marketing: Those activities performed by individuals or organisations, either profit or non-profit, that enable, facilitate and encourage exchange to the satisfaction of both parties.
2. Marketing techniques: Market research, product planning, pricing, channel management and communications management skills that together constitute the marketing mix in traditional market environments, but which are transferable to environments where the opportunity for exchange is absent.
3. Social-cause marketing: The design, implementation and control of programmes calculated to influence the acceptability of social ideas and involving the application of marketing techniques, viz market research, product planning, pricing, channel management, and communications management, to such programmes.

Therefore Thomas sees himself as a marketing 'splitter' as opposed to a marketing 'lumper'. (Lumpers lump together 'subspecies' while splitters classify each as separate 'subspecies'.)

It is ironic that Kotler proposed the broadened concept of marketing and explicitly included the controversial issue of exchange in his definition of marketing, yet neglected to include the exchange process in his definition of social marketing, the crux of the whole issue. Perhaps this is because to him, exchange and marketing are synonymous. That is, he did not feel it necessary to write "the obvious". This, however, is not acceptable when defining a concept and Kotler seems to have realised this, as shall be discussed shortly.

Although Thomas has spotted an inherent flaw in Kotler's definition, his alternative approach to social-cause marketing, which does not demand the presence of an exchange process, is rejected. This is because, as discussed earlier, exchange is not only critical to the concept of marketing, but is completely compatible with the social marketing concept.

Fox and Kotler, and Thomas do concur with respect to their position that social marketing or social-cause marketing should be distinguished from 'societal marketing' (or social responsibility), on the one hand and 'non-profit organisation marketing' on the other:

> 'A societal marketing orientation holds that the main task of the organisation is to determine the needs, wants, and interests of target markets and to adapt the organisation to delivering satisfactions that preserve or enhance the consumer's and society's well-being.' (Thomas: 1983)

> 'Non-profit marketing is concerned with the application of the marketing concept to organisations whose goals are defined not by profit but by other yardsticks of performance.' (Thomas: 1983)

Many writers, however, have given different meanings to the term 'social marketing': In 1973, Lazer and Kelly published Social Marketing: Perspectives and Viewpoints which includes articles on the marketing of social ideas, marketing's social responsibilities and social impacts, all under the term of 'social marketing'. Laczniak, Lusch and Murphy, in their article entitled 'Social Marketing: Its Ethical Dimensions' (1979), include the marketing of urban police departments and political candidates as examples of 'social marketing'.

There is no absolute consensus with respect to the scope of social marketing. However, Fox and Kotler, and Thomas's distinctions provide further insight into this issue.

In the following 'revised' definition of social marketing, Kotler seems to have noticed his previous neglect of the exchange process. Kotler, once again seemingly contradicts the very essence of his definition of marketing, this time as a 'human activity directed at satisfying needs and wants'.

> 'Social marketing is the design, implementation, and control of programs seeking to increase the acceptability of a social idea or practice in a target group(s). It utilises concepts of market segmentation, consumer research, idea configuration, communication, facilitation, incentives, and exchange theory to maximise target group response.' (Kotler: 1988)

Ellis Kowen, recognising this, proposed the following definition:

> 'Social marketing is involved with matters of social concern - it is the marketing of social causes or programmes designed according to identified needs and wants of the target market(s).' (Kowen: 1982)

This implies that in the absence of identified or explicit needs and wants of the target market, a social marketing programme should not be undertaken. Hence we enter one of the most normative, controversial areas in marketing, the realm of welfare. (The issue is discussed in section 3.4: 'Ethical Dilemmas in Preventative Health Care'.)

Fox and Kotler state that 'in many situations people need to be informed of an opportunity or practice that will improve their lives'. (Fox and Kotler: 1980) Thomas questions who can decide what an improvement is and who should have the right and power to define welfare. He argues that Fox and Kotler do not venture far enough into the ethical questions of social marketing and finds their dismissal of the problem naive.

Gaski supports Thomas: 'When a marketer or firm "acts in the public interest", what actually occurs is the attempt to act in the public interest ... For marketers to attempt to serve the best interests of society is not only undemocratic but dangerous as well.' (Gaski: 1985) Additionally, Laczniak, Lusch and Murphy find Kotler and Zaltman's approach to the ethical aspects of social marketing in their original article (1971) to be inadequate. (Laczniak, Lusch and Murphy: 1979)

According to Kotler, 'Social marketers are often attempting to change actions or attitudes of the target market, while business marketers generally try to supply identified needs and wants of their target markets.' (Kotler: 1979) This implies that in the absence of explicit needs and wants, a social marketing programme should not necessarily be impeded. That is, if a social cause is socially beneficial, it would be desired by the presently ignorant target population, were they aware of its value.

Although this dilemma remains unsolved, it is often necessary to make normative, value judgements and decide what is "socially beneficial". That is, implementing a programme to promote a cause to a target market not yet aware of its desirability. (For example, parents, in an attempt to shield their children from the "real world" may not desire a youth-oriented AIDS awareness campaign. However, once informed that the future well-being of their children depends on such a campaign, they may co-operate.)

The following definition of social marketing is therefore proposed.

Social Marketing is concerned with the goals of business and society. It is involved with matters of social concern - it is the marketing of social causes or programmes designed according to current identified and latent needs and wants of the target market(s).

This definition combines:

- the fundamental principle recognised by the originators of social marketing, for example Lazer (1969): 'Marketing shares in the problems and goals of society and its contributions extend well beyond the formal boundaries of the firm'.

and,

- Kotler's view (1988) that: 'Social marketing is the design, implementation, and control of programs seeking to increase the acceptability of a social idea or practice in a target group(s). It utilises concepts of market segmentation, consumer research, idea configuration, communication, facilitation, incentives, and exchange theory to maximise target group response', **and** is 'a human activity directed at satisfying needs and wants'. (Kotler does not combine these two concepts into one formal definition).

This definition comprises the **principles** behind social marketing as well as the **techniques** and **processes** which it involves.

Furthermore, the definition recognises the inherent weakness in Ellis Kowen's definition which implies that in the absence of identified or explicit needs and wants of the target market, a social marketing programme should not be undertaken.

The proposed definition therefore strives to overcome this shortcoming. This modification needs to be clarified: Firstly, 'latent needs and wants' imply that were the target market to know now what the marketer presently knows, it would desire the social

marketing programme. Secondly, marketers who assist others in diffusing social issues or ideas should be held strictly accountable for their actions. This is especially so when the socially beneficial cause does not necessarily coincide with that which is beneficial to the individual.

Therefore, 'social marketing is a hybrid discipline resulting from two perspectives - that of the marketing viewpoint with its approaches, concepts, models, tools and concerns; and that of the social viewpoint with its roots in society, groups of human beings and social problems.' (Lazer: 1969) It requires a deep understanding of the needs and wants, attitudes and perceptions, motivations and lifestyles of the target market. In order to maximise the ease of adopting the idea, communication, product, price and channel strategies should be tailored to complement one another. Social marketing therefore provides a framework for the effective promotion of an idea to a target market.

2.3.2 Types and Processes of Social Change

Fox and Kotler (1980) suggest that three types of situations call for social marketing:

1. When new information and practices need to be disseminated
2. When counter-marketing is needed
3. When activism is needed.

Kotler distinguishes between **four types of social change** which are increasingly difficult to implement.

- Creating **cognitive change** in a target audience requires public information or education campaigns which are not required to change any deep-rooted attitudes or behaviour. Their primary purpose is to create awareness and knowledge (eg: explaining the importance of wearing seat belts). Despite the fact that it seems simple to market cognitive change effectively, Hyman and Sheatsley (1947) have listed a number of reasons why information campaigns fail - thus showing that much thought has to be given even to the simplest of campaigns.

- **Action change** involves persuading a maximum number of people to partake in a specific action within a certain period of time (eg: encouraging people to give blood). The action often involves a cost to the target market. The marketer should therefore arrange factors that make it easy for them to complete the action (eg: mobile blood units).

- **Behavioural change** aims to induce or help people change some aspect of their behaviour for the sake of their well-being. (eg: The achievement of a long term change where a smoker ceases to smoke completely. This would be the ultimate aim of a curative anti-smoking campaign.) According to Barach, social marketers usually assume that motivation to bring about behavioural change in the target market is inadequate or even absent. Communication programmes therefore often reflect an exhortation to increase audience awareness and desires for promoted changes. Barach finds the presumption of the absence of motivation suspect - it is better to assume that the motivation is there, and that either knowledge or solutions are needed. (Barach: 1984)

- **Value change** attempts to alter deeply felt beliefs or values that a target group holds towards some object or situation (eg: efforts to alter people's ideas about abortion).

> 'The attitudes and beliefs of a target audience are like a river flowing down a mountain. By working with the flow, fields can be irrigated, lakes can be created, electricity can be produced. All these things can be accomplished, provided the river is not asked to run uphill.' (Barach: 1984)

Thus a person's sense of well-being and identity are rooted in their basic values and the intrusion of dissonance into their values creates stress which often results in the human psychological system resisting such information.

Whereas Kotler deals with **four types of social change**, Sheth and Frazier, based on the concept of attitude - behaviour consistency/discrepancy. suggest that there are **four major processes** of planned social change, each one most appropriate for each of four combinations of attitude - behaviour consistency/discrepancy as summarised in the table below: (Sheth and Frazier: 1982)

	ATTITUDE	
	POSITIVE	**NEGATIVE**
Engaged	Cell 1 Reinforcement Process	Cell 2 Rationalisation Process Attitude Change
RELEVANT BEHAVIOUR		
Non-engaged	Cell 4 Inducement Process Behavioural Change	Cell 3 Confrontation Process

TABLE 1: THE SHETH-FRAZIER FOUR MAJOR PROCESSES OF PLANNED SOCIAL CHANGE

- When attitudes and behaviour are consistent as well as in the positive direction toward the relevant social behaviour (cell 1), a **reinforcement process** seems most appropriate. This refers to rewarding people for engaging in a behaviour they enjoy which the social marketer wants to sustain.

- An **inducement process** is most appropriate when people possess a positive attitude toward a desirable social behaviour but do not or cannot presently engage in concomitant behaviour (cell 4). This refers to minimising or removing constraints which intervene between the positive attitude and the consequent behaviour. Behavioural change, resulting in a movement from cell 4 to cell 1 is desired.

- The **rationalisation process** is most appropriate when people are currently engaged in a desirable social behaviour but have a negative attitude toward it. (cell 2) The primary objective is to generate attitude change consistent with the behaviour thereby facilitating a movement to cell 1.

Therefore, this model goes a step further than Kotler who just distinguishes between types of social change. This is a model of strategy choice - not only does it segment the market in terms of this attitude-behaviour consistency/discrepancy framework, but it suggests that the social marketer selectively utilises the mix of influence strategies discussed.

2.3.3 The Social Marketing Process

When planning a social marketing strategy, it is essential to understand the social marketing process: its elements, problems and challenges. In order to optimise the effectiveness of the strategy, it is critical to combine this marketing approach with the management processes of planning, organising, implementing and evaluating.

a) Problem Definition

Social marketing cannot be effective unless it is addressed to the right problem. The marketer must therefore not only examine psychological forces but economic, political, cultural and all other relevant variables affecting the marketing process.

b) Goal Setting

It is not only critical to set clear, measurable goals which one can hope to accomplish, but to establish benchmarks for evaluating the success of the programme.

c) Market Analysis

Marketing research is critical to, and forms the foundation of the social marketing campaign.

Social marketers have less secondary data available to them and have difficulty in obtaining valid, reliable measures of salient variables. Additionally, they encounter more difficulty sorting out the relative influence of identified determinants of consumer behaviour and in getting consumer research studies funded, approved and completed in a timely fashion. (Bloom and Novelli: 1981)

d) Market Segmentation

The process of dividing up the market into homogeneous segments and then developing unique marketing programmes for individual target segments chosen, is the next highly critical step in the formulation of a marketing strategy. Many different segmentation strategies are available to the social marketer who has the responsibility of choosing the most suitable base. (eg: The Sheth-Frasier approach, level of fear approach.)

Challenges in this area include:

- Pressures against segmentation in general and especially against segmentation which leads to ignoring certain segments
- Lack of accurate behavioural data to use in identifying segments
- Less flexibility in shaping their offerings and formulation 'product' concepts
- More difficulty in selecting and implementing long term positioning strategies

e) The Manipulation of the "4 P's"

Once the foundations for the marketing strategy have been laid, it is critical to co-ordinate and plan the product, promotion, pricing and place policies such that they complement the goals and objectives of the organisation and are congruent with the desires of the target market.

i) Product Strategy

Since the "product" concerned is intangible, wherever possible, the social marketer searches for a tangible product to facilitate adoption of the desired behaviour. Challenges involved in product strategy include inflexibility in shaping products or offerings, difficulties in formulating product concepts (eg: drug therapy maintenance) and problems in selecting an acceptable or attractive long term positioning strategy. However, social marketers should realise that although they may be unable to adjust the performance of their products, they may be able to adjust the perception characteristics thereby achieving significant results. (Bloom and Novelli: 1981)

ii) Promotion Strategy

Social marketers usually have large amounts of information to communicate in a message, and often face pressure not to use certain types of appeals in their message. (Rothschild: 1979). The use of the most suitable methods and appeals is essential. For example, the use of fear appeals in communication programmes is subject to much debate. This is primarily owing to the possible negative effects of anxiety stimulation. (This is discussed in more detail in 4.4.1)

iii) Pricing Strategy

The price component is often neglected because it is often unclear what the "price" is in a given social marketing transaction, particularly where one is talking about trying to change deep-rooted social attitudes and behaviours. (Andreasen: 1984)

Social marketing price strategy involves trying to reduce monetary, psychic, energy and time costs incurred by consumers when engaged in a desired social behaviour. (Bloom and Novelli: 1981)

For example, many women do not undertake monthly breast cancer self-examination (BSE) because they perceive the "price" to be too high: i.e. giving up the peace of mind that would result from avoiding BSE. The social marketer, may reduce this "price" by assuring women, that in the event of a problem, much progress has been made in treating breast cancer.

Social marketers have difficulties estimating prices and have less control over consumer costs, for example, there is little one can do to reduce the embarrassment of an examination. In many cases, all the social marketer can do is to try to make sure that consumers perceive the various costs accurately and not to inflate them in their minds. (Bloom and Novelli: 1981)

iv) Channel Strategy

Social marketing campaigns often have to be taken down to community level, hence the need for the co-operation of a number of influence channels to carry out their programmes.

> 'Difficulties arise with respect to convincing intermediaries to spread or support the idea, controlling intermediary actions and providing incentives to ensure co-operation. Generally social marketers cannot afford to build their own distribution channels and are often forced to rely on the attractiveness of their offerings and creativity of their appeals for assistance to encourage volunteers.' (Bloom and Novelli: 1981)

The channel component is often **underplayed** since it is seen primarily in terms of delivery alternatives which can make the exchange physically easier for target customers. According to Andreasen, the domain of the use of various middlemen agencies to carry out important aspects of marketing programmes has been largely neglected in social marketing literature. The social marketing agency should act as a "manufacturer" and the middlemen as the "retailers" of the social marketing "products". It is the central argument of this article that strategies for recruiting and then motivating, controlling and coordinating middlemen in a social marketing programme should be based on explicit use of power. (Andreasen: 1984)

The strategy alternatives available to the social marketer can be grouped into three broad categories:

1) requiring middlemen participation and co-operating through the use of coercive, traditional, legitimate and legal legitimate power.
2) rewarding middlemen participation and co-operation through the manipulation of reward or referent power.
3) persuading middlemen to participate and co-operate through the use of expert and informational power.

To envision how the power potential approach may be made operational, consider the following concrete example in which a social marketer utilises hospital nurses to induce more individuals to give up smoking. (Andreasen: 1984)

Coercive Power:
Suggest that they have a special responsibility to themselves and their patients to promote the giving up of smoking.

Traditional Legitimate Power:
Tell nurses that it is part of their professional obligation to induce people to give up smoking.

Legal and Legitimate Power:
Require education in behaviour change techniques to be part of nursing licensing requirements.

Reward Power:
Publicise nurses' contributions to the smoking programme and/or offer specially framed certificates to individual nurses for participation.

Referent Power:
Create a crusade-like atmosphere where all health professionals are working together on a major health problem and/or offer to write letters to each nurse's employer commending the nurse's co-operation with a major federal health effort.

Expert Power:
Show that this social marketing organisation is an expert in marketing behaviour, change tools and techniques and offer to share this expertise as part of participation.

Informational Power:
Produce first quality brochures, films, posters for patient education with nurses' co-operation prominently portrayed.

Therefore, the long term role of middlemen in a channel relationship is closely related to the type of influence exerted by the social marketer and power, as discussed, is a basis for such influence.

This is certainly an innovative approach but empirical proof that it is indeed operational is lacking. However, this should not detract from its potential power. This 'power potential' strategy should be utilised and adapted to the specific situation in order to further improve the effectiveness of the social marketing campaign.

f) Evaluating Social Marketing Campaigns

This is as critical in social marketing as in any other area. However, social marketers frequently face difficulties trying to define effectiveness measures, and often find it hard to establish the contribution of their marketing programme to the achievement of certain objectives. (Bloom and Novelli: 1981) Nevertheless, it is possible: The effectiveness of family planning campaigns may be assessed by looking at sales data of contraceptives, distribution systems, change in knowledge and practices of consumers, cost-effectiveness, and, at the macro level, changes in fertility and birth rates.

It is important to note that this is a guideline to formulating a social marketing strategy, not a hard and fast rule. Additionally, it should be remembered that every situation is different. For example, promotion policy may be pivotal in one campaign while distribution policy may be more important in another. Therefore in order to achieve the "optimal mix", thorough research should be conducted on an ongoing basis.

2.3.4 Required Conditions for Effective Social Marketing

There are many different views on the required conditions for effective social marketing:

Lazarfeld and Merton found that the lack of supplementation (a step-down communication process), monopolisation (absence of counter-propaganda) and canalisation (the presence of an existing attitudinal base with respect to a campaign), are critical factors which prevent the effectiveness of any social marketing campaign. (Kotler: 1982 and Wiebe: 1951)

Wiebe suggests that the more the conditions of the social campaign resemble those of a product campaign, the more successful the social campaign. However, since many social campaigns are conducted under quite unmarketlike circumstances, he identifies five factors which account for the relative effectiveness of these campaigns. (Kotler: 1982 and Rothschild: 1979)

1) **The force:** The intensity of the person's motivation toward the goals which is a combination of his predisposition prior to the message and the stimulation of the message. (eg: the desire to improve health through weight loss)
2) **The knowledge** or direction of how or where the person might go to consummate his motivation. (eg: diet)
3) **The existence of an agency** (the **mechanism**), which enables the person to translate his motivation into action.(eg: weight reducing clinics)
4) **Adequacy** and **compatibility:** The ability and effectiveness of the agency in performing its task. (eg: lectures by doctors and people who have been overweight and have reached their goal weight)
5) **Distance:** The audience members' estimate of the energy and cost required to consummate the motivation in relation to the reward. (eg: ease of access, convenient hours)

The above illustrates that a social marketing campaign which provides the 'force', the 'direction' and the 'mechanism' as well as maximising 'adequacy', and minimising 'distance' is an effective strategy.

In Rothschild's analysis, he tries to understand why social causes are more difficult to market than commercial products, and within social causes, why some are much more difficult to market than others.

He identified factors which affect the impact of any social cause campaign. (Kotler and Rothschild: 1979) They include: (with respect to the issue of protecting the ozone layer)

1. Situation Involvement:
   There is low current involvement, that is, this issue has very low salience compared to other issues people face.
2. Enduring Involvement:
   People have generally not had much involvement with this issue in the past.
3. Benefits/Reinforcements:
   Since an individual who ceases to use ozone-harmful products does not seem to make a significant difference to the amount of such products available or used, such behaviour only produces slight personal satisfaction.
4. Costs:
   Adopting 'ozone-friendly' behaviour may involve making sacrifices.
5. Pre-existing demand:
   There is some latent demand for preventing radiation through protecting the ozone layer but it is not very strong nor universal.
6. Segmentation:
   This issue should be marketed to everyone, as it is a worldwide problem.

Thus, the greater the involvement, the presence of 'benefit reinforcement', low costs, pre-existing demand and a suitable segmentation strategy should increase the impact of any social cause campaign. A social marketing campaign to protect the ozone layer would be an extremely challenging task.

The Smelser/Kotler analysis postulates that the success in marketing a social cause depends on society's readiness for that cause, which varies at different times. (Kotler: 1982)

Therefore, in order to enhance the effectiveness of a social marketing campaign, it is essential to take cognisance of the different viewpoints expressed above regarding "required conditions for effective social marketing".

2.3.5 Criticisms of Social Marketing

According to Fox and Kotler there are four classes of criticism of social marketing: (Fox and Kotler: 1980)

1. Social Marketing is not Real Marketing
   Many marketers believe that marketing is primarily a business discipline with no application to social causes. As stated by Laczniak and Miche (1979) marketers should 'take enough pride in the scope of traditional marketing'.

2. Marketing is Manipulative
   Many marketers see social marketing as bringing society closer to Orwell's 1984. Laczniak, Lusch and Murphy (1979) believe that social marketing is potentially unethical in giving power to a group to influence public opinion on controversial issues. The word 'manipulative' usually connotes hidden and unfair ends or means used in the influence process.

Fox and Kotler argue that if a cause is marketed openly with the purpose of influencing a person to change his/her behaviour, then the process is not manipulative. Additionally, in response to such accusations, Kotler states not only is it very difficult to change a person, let alone a whole group of people, but that social marketing goes on in society whether or not its methods are openly described. The latter implies that rather than keeping social marketing methodology a deep secret, it should be openly discussed and examined thereby leading to the resolution of public issues on their merits. (Kotler: 1982)

3. Social Marketing is Self-serving

   Clearly, commercial enterprises will increasingly support social marketing programmes if financial benefits are expected. However, this is desirable since they are promoting socially beneficial programmes, often with more resources than an underfinanced cause organisation.

4. Social Marketing will Damage the Reputation of Marketing

   Some marketers fear that social marketing will arouse negative sentiment towards marketing as a whole. Since Fox and Kotler see social marketing as a means to enhance the quality of life, they find this objection unacceptable.

This list is by no means conclusive. Not only does it omit the critical issue of the ethical dimension of welfare (as discussed earlier), but fails to mention other reasons for resisting the concept: eg: social marketing will increase the amount of 'promotional noise' in the society, which is found distasteful both because it emphasises 'trivial differences' and because it is 'noise'. Additionally, social marketing has been accused of increasing the costs of promoting social causes beyond the point of net gain either to a specific cause or to the society as a whole. (Kotler and Zaltman: 1971)

2.3.6 Social Marketing and Social Responsibility - A South African Evaluation

The following statement explains the core of social responsibility:

> '(At) any one time in any society there is a set of generally accepted relationships, obligations and duties between the major institutions and the people. (This) set of common understandings (can be called) the social contract.' (Robin and Reidenbach: 1987)

Robin and Reidenbach (1987) define social responsibility as the set of generally accepted relationships, obligations and duties that relate to the corporate impact on the welfare of society. Furthermore, they suggest that socially responsible organisations adopt the following values:

1. Caring for organisational family (i.e. employees, management, shareholders).
2. Caring for integral publics (e.g. customers, creditors).
3. Being a helpful and friendly corporate neighbour.
4. Obeying the law.
5. Being a "good" citizen in the community, the nation and the world.
6. Allocating a portion of the companies' pre-tax profits to social responsibility...
7. Protecting and caring for the physical environment on which the organisation has an impact.

The marketing concept is growing in South Africa but, as yet, few have adopted the social marketing concept. Those who have are largely non-profit organisations such as National Cancer, and Beauty Without Cruelty, which, despite limited funds have been fairly successful.

Despite some still believing social responsibility to be "fundamentally subversive doctrine", and many maintaining 'that a corporation or company is a castle and outside interests should not prescribe to it' (Uys: 1987), many South African businessmen have undertaken corporate social responsibility activities. (This is especially so since the 1976 Soweto Riots.)

The multinational oil companies have been at the forefront of social responsibility campaigns in South Africa. This is primarily owing to foreign pressures and the need to justify their presence in South Africa. However, there is a fast growing emphasis in South Africa away from the sheer managerial and profit motive towards a social responsibility awareness - an 'enlightened self-interest'.

> '...the area of Social Responsibility has over the years evolved from its initial stage when "fringe benefits" activities were seen as something external to normal business practices, to the current position where its impact on key business areas is part and parcel of corporate objectives. Corporate Social Responsibility (CSR) spending in South Africa increased from approximately R600 million in 1988 to approximately R800 million in 1990. Larger companies spent about 1% of after-tax profits on CSR spending in the early 80's, and between 2 and 5% in the late 80's - about the same level as the USA and the UK.' (Chamber of Commerce Weekly Bulletin: 1991)

A socially conscious and responsible corporate image is an extremely important asset for a company operating in South Africa. Such an image should not only improve profits, but create an environment in which the company can operate successfully, both in the present and the

future. Acceptance by the communities in which it operates is an investment in the future survival of the company.

Corporate social responsibility covers a wide spectrum of activities. Although many distinguish between **internal** social responsibility (general employee practices, employee benefit schemes, business ethics) and **external** social responsibility (company involvement in community affairs), it should be understood that the two are **inextricably linked**. Corporate social responsibility should be a commitment of the company to be co-responsible for the quality of life of the community in which it operates.

Therefore, this approach is certainly **compatible** with the social marketing concept discussed: Kotler and Levy (1969) show that marketing is applicable to all areas where an organisation attempts to relate to its customers and other publics too. Lazer (1969) argues that 'marketing must serve not only business but also the goals of society...'. (see 2.2) External social responsibility is therefore congruent with "external" social marketing, and internal social responsibility complements "internal" social marketing. However, the social marketing qualities of 'design', 'implementation', 'control' and 'continuity' would enhance the long term effectiveness of a social responsibility programme.

Thus the potential scope for the transformation of corporate social responsibility programmes (both internal and external) into social marketing programmes in South Africa is vast. This includes big business, small business and non-profit organisations.

2.4 Summary

The above discussion on social marketing provides insight into the multifaceted concept which is fundamental to this dissertation.

The **principles** behind social marketing have been discussed by contrasting the opinions of the specialists in the field. The **processes** involved in social marketing highlight how marketing techniques can be applied to social causes. Together, these principles and processes provide a powerful mechanism for the achievement of an organisation's objectives.

The broad foundation has thus been laid. Since this dissertation involves social marketing and AIDS, chapter 3 entails a discussion of the application of social marketing to preventative health services.

CHAPTER THREE

SOCIAL MARKETING AND PREVENTATIVE HEALTH SERVICES

3.1 Introduction

The aim of this section is to discuss social marketing and health promotion, showing how the **Theory of Social Marketing can be Applied to Family Planning** (3.2). Special emphasis is placed on a **Practical Example of a Successful Family Planning Campaign** (3.3). Furthermore, the highly topical and relevant issue of **Ethical Dilemmas in Preventative Health Care** (3.4), is discussed.

The World Health Organisation (WHO) defines health services as those services concerned with the maintenance of a maximum number of physically and mentally sound individuals within a given community. These health services may include curative and preventative practices. Curative medicine comprises programmes designed to maintain or improve current standards of health. Preventative medicine strives to ensure that a situation, where curative medicine is necessary, does not occur. Since prevention is usually far more desirable than cure, social marketing is often utilised to optimise the effectiveness of preventative health care campaigns.

According to Fox and Kotler, family planning and preventative health care are the two major achievements of social marketing. (Fox and Kotler: 1980)

Integrating preventative health care into the process of planning a social marketing strategy, as discussed earlier, seems fairly straightforward. After the problem definition, goal setting, market analysis and market segmentation, the design of the marketing mix would follow. This would involve developing the right preventative health service package with the right promotion (communication strategies) at the right "price" and right "place" (channel strategy). However, all is not as simple as it seems and the social marketer faces many challenges: For example, although the target market usually has a positive attitude towards health services, it is often not prepared to undertake the necessary preventative measures to ensure lasting health. (According to Sheth and Frazier (1982), this requires an inducement process.) Secondly, since the aim of health programmes is often behaviour change, the target market's "post purchase" behaviour becomes far more important than the "adoption" of the product or concept. Hence the critical importance of feedback and 'follow-up' or reinforcement programmes. That is, the social marketing of health services should be continuous over a period of time, not a 'one-off' effort.

The proposed definition

> **Social Marketing is concerned with the goals of business and society. It is involved with matters of social concern - it is the marketing of social causes or programmes designed according to current identified and latent needs and wants of the target market(s).**

really shows its value in the area of preventative health: Since it is generally accepted that most individuals prefer to be healthy and live in a healthy environment it can be assumed that they will desire a campaign aimed to achieve this as soon as they are made aware of its value. Therefore, although the process may initially be one-sided, it will soon become reciprocal, thereby fulfilling the concept of exchange.

3.2 The Theory of Social Marketing Applied to Family Planning

A family planning campaign may seek to move the target market through the following changes identified by Kotler:

1. **Cognitive change**, eg: the creation of awareness and knowledge of the 'population explosion' problem and explaining the importance of birth control.

2. **Action change**, eg: this involves encouraging the target market to practice birth control.

3. **Behavioural change**, eg: this involves teaching the target market how to use birth control methods in order to establish regular use without anyone being around to reinforce this habit.

4. **Value change**, eg: where change would occur in the value systems of the target market with respect to the optimal family size.

The Sheth-Frazier attitude-behaviour consistency/ discrepancy approach to family planning can be illustrated in the following framework: (Sheth and Frazier: 1982)

Cell 1 couples practice birth control and have a positive attitude	**Cell 2** couples practice birth control purely out of necessity
Cell 4 couples firmly believe in birth control but do not practice it	**Cell 3** couples avoid birth control because they have a negative attitude towards it

TABLE 2: THE SHETH-FRAZIER APPROACH TO FAMILY PLANNING

If, for example, the target market falls into cell 3, a **confrontation strategy** is recommended. Behavioural confrontation requires the social marketer to create blockades towards not using birth control methods and to alter their motivations towards contraception. Psychological confrontation involves a direct attack on the existing attitudes which the target market has towards birth control.

Since this is a highly complex and difficult process, a gradual approach is recommended.

3.3 A Practical Example of a Successful Family Planning Campaign

> 'The promotion of family planning was introduced in Louisiana as early as 1965, and a state-wide programme was in operation by 1967. Currently the Louisiana programme serves as a model to other such family planning programmes: the 'Louisiana model'. The success of this model can be attributed to several factors: (El-Ansery and Kramer: 1973)

1. Consumer Orientation

The primary target market included low-income, underprivileged females between the ages of 15 and 44. Adopters of family planning methods were labelled customers. The programme's personnel were taught that they were selling an idea rather than giving a free service.

A fundamental programme philosophy was initiated: take the service to the customer, rather than the traditional philosophy of bringing the customer to the service source. For example, a potential customer was visited at home by a family planning counsellor who informed her about the nature of family planning, services available and benefits which could be derived from such services. If the potential customer wanted to know more, she/he was scheduled for a session held in the clinic. Those

who accepted appointments but did not keep them were followed up by a computer-generated letter, then later on with another home visit by the counsellor. The programme's objectives were designed to provide services needed by the customers.

2. Marketing as a Process with Many Participants

The programme's management realised that they were involved in a marketing process with many participants, some being very sensitive to the issue. They therefore avoided mass media communications and concentrated on the personal selling approach to individual potential customers. This strategy was altered as the environment became more receptive.

3. Integrated Effort

A marketing mix as well as a research programme was designed.

Product Offering:

The programme's product was seen as a bundle of benefits to be desired through participation. The services offered were designed in terms of medical and human services, as well as the friendly atmosphere of the clinic.

Price:

The clinic personnel were taught to take into account the opportunity cost to the customer of visiting the clinic.

Distribution:

To reduce service delivery time, strategic locations were selected for the clinics. Also clinic layout was planned to reduce time consumed in information and physical flows. It was realised that improving the service level would not only result in more active customers, but also in better utilisation of resources.

Promotion:
Promotion tools included a public relations division and a personal selling function. A merger of these two divisions would be considered when mass media communication became feasible.

Marketing Research and Information:
Continuous research programmes to test the effectiveness of the clinic system were undertaken as well as surveys to determine reasons for accepting or not accepting participation, as well as for keeping or not keeping appointments. Additionally a management information system designed to collect all relevant consumer information continuously was introduced to serve as a base for future marketing strategy.

4. Profitability for Long Term Viability

Although this is a non-profit foundation, close attention was paid to the cost of producing these services. (cost-benefit analysis) The Louisiana Family Planning Programme determined not to be 'myopic', defined its business broadly and generally as human services rather than family planning. Since the primary target market of the programme was under-privileged, low-income females, the service mix was designed to break the 'illness - ignorance - poverty cycle characteristic of certain socio-economic strata in the American society'. The service mix included family planning, child care, and parent training programmes. The foundation's resources could not support entrance into these three fields. Therefore family planning - health care was given first priority, child care second and parent training programme third.

The Louisiana Family Planning Programme has not only become of national value but of international value to for example, Brazil, Colombia, Turkey. It is, however, critical to realise that this model is not suited to every environment and should therefore not be imposed without research into the specific situation.

Thus, this example provides one with a clear illustration of how the theory of social marketing can be applied to enhance the effectiveness of a campaign. Although the success of social marketing family planning campaigns does not guarantee an effective social marketing AIDS prevention campaign, many challenges which face an AIDS education programme have been overcome in family planning programmes. Thus this section may serve as a guideline and basis for such an AIDS campaign.

A discussion on **Ethical Dilemmas in Preventative Health Care** follows.

3.4 Ethical Dilemmas In Preventative Health Care

> 'Prevention (in the health field) is not only the act of taking a series of measures designed to avoid the occurrence, as well as the progression of disease and permanent disability, but also the timely application of all means of promoting the health of the individuals and the community as a whole.' (Doxiadis: 1987)

The following quotation from a statement by Sir George Young, former Minister of Health of the United Kingdom, could not better summarise the task ahead in prevention and its ethical dilemmas: (Doxiadis: 1987)

> 'The solution of many present health problems will not be found in hospital research laboratories but in our parliaments. Diseases which kill most nowadays are due to our lifestyle and the reaction against these illnesses is not cure but prevention.'

The idea of maintaining health by prevention is not new. It might be argued that preventing pain, disability and premature death require no justification.

However, many complex dilemmas surround the issue of preventative health care which include social, cultural, ethical and economic factors. In fact the central issue around which the questions revolve is the conflict of duties, rights and responsibilities between the government and the individual, between society's welfare and individual welfare. Examples include:

1. Should the government resort to paternalistic legislation such as limits to drinking or smoking? (Doxiadis: 1987)

In recent decades, a significant portion of early deaths stems from personal risk-taking, that is, life-style risks. Paternalism to protect the public health is not only compatible with democratic values, but that types of paternalism, like public health restrictions, are essential to defend the common life and to promote a sense of community. (Doxiadis: 1987)

The backbone of antipaternalism is the harm principle as captured in the John Stuart Mill's famous essay 'On Liberty'. The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. This would appear to imply that drunk driving would be a public problem but alcoholism would not. However, preventative measures to improve health, such as air and water pollution control, are often justified as non-paternalistic as private actions alone cannot bring them into being.

Perhaps a moderate form of paternalism is positive since it may not only encourage the individual to improve his/her own lifestyle, but society's welfare too.

It should be noted that when governments act in a field of complex, sensitive issues, additional difficulties arise. For example, a government may be reluctant to take the appropriate actions in tackling the problem of alcohol abuse if alcohol is a major source of revenue for the country concerned.

2. How can the value of individual freedom and the welfare of the society as a whole be reconciled in the field of health?

   - When does government intervention become government intrusion?
   - When should the rights of the society take precedence over the rights of an individual?

- To what extent is the adoption of health-promoting behaviour an individual responsibility?
- Has the individual the right to take health risks of his/her choice? Should society bear the burden of this?

> 'Survival of the herd is perhaps the most fundamental objective of society. The reality, however, is that individuals are unimportant to herd survival, and in practice the promotion of health cannot be achieved without cost, effort or resources, bringing it into conflict with competing demands, and compelling the 'value of life' to take its turn in the list of social priorities. That is, there is a tendency for people to be more concerned with the concrete immediacy of the present than with possibilities of the future.' (Doxiadis: 1987)

It is essential to realise that while we must aim at formulating ethical rules and control procedures with wide validity and applicability, this is not always possible. Therefore, the ultimate aim should be to minimise the conflicts rather than to strive for a perfect solution. This can only be achieved if both the decision makers and the general public are made aware of the critical ethical problems involved in preventative health care issues.

3.5 Summary

Chapter 3 has shown that there is much scope for the application of social marketing techniques to preventative health services. However, the complex ethical dilemmas which surround the issue of preventative health care demand careful attention.

The following chapter is the final chapter of the literature review. It covers the implications, consequences and issues surrounding AIDS, with special reference to social marketing and AIDS prevention in the workplace.

CHAPTER FOUR

AIDS AND SOCIAL MARKETING

4.1 Introduction

The purpose of this section is two-fold. Firstly, to clarify and consolidate the core issues and facts about AIDS. This discussion includes: A Brief Medical Background (4.2); The Impact of AIDS (4.3); General Preventative AIDS Education (4.4), and AIDS Prevention in the Workplace (4.5). Secondly, to show that **AIDS Prevention in the Workplace is a Just Cause for Social Marketing** (4.6).

4.2 Medical Background

Epidemiological studies throughout the world have demonstrated that to date, the HIV virus is transmitted in only three ways:

a. through (unprotected) sexual intercourse
b. through blood
c. from infected mother to infant

There is no evidence that HIV transmission involves insects, food, water, toilets, shared drinking and eating facilities, etc. There is therefore no evidence that HIV can be transmitted through casual contact in the workplace.

From a medical point of view, AIDS is a complex and unusual disease. It is important to understand the medical status denoted by the terms:

HIV

This is the virus which causes AIDS. The "window period" refers to the first few months after a person becomes infected, when a blood test cannot detect the presence of the virus. The virus can still be transmitted.

HIV POSITIVE & THE ASYMPTOMATIC CARRIER

All persons with a positive test can transmit the disease. The asymptomatic individual is HIV positive but has no symptoms or illness related to the disease. This may last for up to ten years.

AIDS RELATED COMPLEX OR ARC

These people have damaged immune systems and are often sick with fever, fatigue, weight loss etc.

AIDS

The medical condition AIDS represents the terminal phase of infection with the HIV virus. This virus gradually destroys the body's natural immunity. The majority of AIDS patients die within one or two years of diagnosis.

Therefore, the "unique" nature of AIDS - an average of ten years can lapse before HIV-infection transforms into AIDS - is critical to understand.

There are two distinct patterns of the spread of AIDS in South Africa:

'The main difference between the AIDS epidemic in South Africa and elsewhere in the world, besides its relatively late onset, is the presence of two distinct patterns of spread which follow racial divisions: Pattern I occurs in white male homosexuals and Pattern II is seen in the black heterosexual population... There is a very significant trend towards the development of Pattern II or African AIDS, whereas in the white population, the growth of this epidemic is showing preliminary evidence of slowing down, as has been observed in Pattern I countries abroad.' (Christie: 1991)

4.3 AIDS and its Impact

Although the first cases of AIDS (the Acquired Immune Deficiency Syndrome) may have occurred as early as 1978, AIDS was only first described in America in 1981.

At present, the extent of the AIDS epidemic is not as great as other epidemics such as tuberculosis and malaria where mortality figures probably run into millions per year, particularly in Third World countries. Additionally these epidemics were difficult to avoid, whereas with proper education programmes, the spread of AIDS could be slowed. Despite this, AIDS has had an enormous impact on society, and according to Keith Edelston, author of 'AIDS, Countdown to Doomsday', it may be more of a threat to humanity and mankind than 'Bubonic Plague' - the Black Death. (Edelston: 1988)

- Is this preoccupation paradoxical?

Certainly not, despite Keith Edelston's rather extreme 'Doomsday scenario', AIDS warrants far more attention than it is already receiving.

The mechanisms of transmission of AIDS call attention to sexual, reproductive, and addictive behaviours. These are extremely sensitive and problematical areas for intervention. There is no preventative vaccine nor cure, and unlike most other infections, AIDS is invariably fatal.

A discussion on the impact of AIDS in terms of "the statistics", "economic consequences", and "implications for employee benefit funds" follows.

4.3.1 The Statistics

Owing to the time span from HIV until full-blown AIDS, the present number of AIDS cases is only an indication of the number of people with HIV. Many different models have been developed, worldwide and in South Africa, for predicting the impact of AIDS.

> 'In the absence of a comprehensive data set, however, the most reliable short term projection of HIV infection comes from Padayachee and Scholl (1990). They postulate that the prevalence of HIV infection increases exponentially with a doubling time of 8,5 months, and predict that between 317 000 and 446 000 black South Africans aged between 15-59 years will be infected by the end of 1991.' (Christie: 1991)

Although many of the "experts" have different views on the exact extent of the epidemic, all predict grave consequences. The following quotations illustrate the potential enormity of the spread of AIDS:

The following is an extract from the Argus newspaper editorial:

> The scourge of AIDS - the incurable sexually transmitted disease which was diagnosed for the first time only 10 years ago - now threatens the world's population like no other disease before it...
>
> Already the World Health Organisation estimates that for every known case of AIDS, there are 100 people who carry the virus. Africa is one of the worst affected continents. In South Africa alone 250 000 people are currently affected - and this figure is doubling every eight-and-a-half months.
>
> In our country fertile ground has been created for the spread of AIDS through poverty, malnutrition and lack of adequate housing. And the consequences of this neglect will be continued to be felt in the spread of the AIDS virus well into the 21st century. (Argus: June 7 1991)

> More than 5000 new cases of AIDS were reported to the World Health Organisation during June, raising the official global total to 371 802 cases. WHO predicts that up to 40 million may be infected with the virus by the end of the century. (Cape Times: July 1991)

In South Africa, three cases of AIDS were diagnosed in 1982.

> A minimum of 100 000 people are now infected with the HIV virus in **South Africa** and this figure is expected to rise to 200 000 within a year. (Carswell: 1991)

> HIV infection in South Africa will peak in the year 2005 and then level off... If behaviour does not change... by 2005, more than 7 million could be infected...(Steinberg: 1991)

Many different models for predicting the impact of AIDS have been formulated. For example, the broad conclusions from Metropolitan Life's AIDS model (1990) include that: It is unlikely that the doomsday forecast of over 50% of adults infected by the year 2000 will be realised.

Several AIDS forecasting models have been developed for possible use in South Africa. For example: Padayachee and Schall (1990). In their article "Doomsday forecasts of the AIDS epidemic", they argue that sensationalised forecasts of the AIDS epidemic may adversely affect forecast of the disease. Sensationalism causes hysteria which hinders programmes designed towards reducing the spread of HIV/AIDS. Therefore, informed, realistic forecasts are needed.

The potential magnitude of the spread of AIDS, as discussed above, has many repercussions. The first to be considered are the economic consequences.

4.3.2 Economic Consequences

Many have predicted that, by the end of the century, the AIDS epidemic will begin to have visible economic consequences:

With respect to **economic planning:**

> Long-term planning of such matters as schools, hospitals, water supplies, electricity supplies, housing development and urban development, are all profoundly affected by this totally new demographic perspective. For example, it has been estimated by the Urban Foundation that there is a housing need of some 4.7 million housing units in the next ten years... The question arises as to whether the industry should be geared up to this level of performance when new demand will suddenly disappear at the turn of the century? (Osborn: 1990)

According to the Urban Foundation (1991), AIDS will not remove development problems by drastically reducing the population.

With respect to **economic consequences:**

> '...(The) problem for South Africa has been seen to be the adequate provision of jobs for a burgeoning population. ... There is a requirement of 350 000 new jobs a year to cope with the rising population. ... This may well still be the requirement during the 1990's... But thereafter, as the numbers of sick and dying soar, the entire nature of the labour market will change drastically. The numbers of skilled and semi-skilled will, increasingly be in short supply...and shortages of able-bodied unskilled labour could emerge...' (Osborn: 1990)

According to Barrel, (1990):

> 'By reducing the level of efficiency of much of the most active section of the world's population, and eventually removing such people from the scene altogether, AIDS will effectively reverse the expansion in the exchange of goods and services that has fed economic growth, we could be faced with economic "retrogression"...
>
> AIDS will inevitably influence demand patterns. Demand will continue, but at a lower level, and for more basic and less expensive items. This is bad news for suppliers of what is known in economic parlance as conventional necessities...'

Therefore, although there is no overall concensus with respect to the enormity of the AIDS epidemic, the above, (4.3.1 and 4.3.2), illustrate the **dangerous direction towards which all the statistics point. This cannot be ignored.**

4.3.3 The Impact of AIDS on Employee Benefit Funds

The impact of **AIDS on Employee Benefit Funds**, is a much debated, highly sensitive issue.

> 'The costs to both employers and employees will be high in terms of drugs, sickness, lost productivity, and also benefits payable by funds. The question is what funds can be afforded. As an employer your costs will depend on: your recruitment policy, your benefit design and your employment policy, all in relation to the profile of the persons in your employment. The impact of costs will therefore vary from employer to employer according to the types of benefit policies provided.' (Van der Linde: 1990)

The following extracts clarify the impact on different types of funds: (Le Roux: 1990)

HOW PREMIUMS ARE AFFECTED:

If 10 people are assured for R1000 each, and if one death is expected in a year, then the premium each person will have to pay will be: R1000 divided by 10 = R100 each.

If, due to AIDS, the expected number of deaths increases to two in the year, then the premium becomes: R100 times 2 divided by 10 = R200 each.

The Impact of AIDS on:

- GROUP LIFE ASSURANCE:

  Mortality rates are going to deteriorate and life insurance premiums, both on an individual and group basis, will have to increase. This is particularly so in the case of lump sum benefits. Where the benefit is in the form of an instalment, or annuity, payable to a spouse, the impact will be less, as there is a high probability that the spouse will also be infected and therefore also subject to a shorter life expectancy.

- DISABILITY INSURANCE

  In similar vein, lump sum disability benefits will be adversely affected, while disability income benefits will be less severe, as the claimant will probably pass away fairly soon, thus limiting the number of monthly payments that will have to be made.

- RETIREMENT FUNDS

  Provident funds, where lump sum benefits are paid at retirement, will not be affected. Pension Funds will be better off, due to the fact that pension instalments will probably have to be paid for shorter periods than normal. An indirect factor that will affect Retirement Funds negatively, is the possibility of lower investments returns that could result from the expected economic decline.

- MEDICAL AID AND HEALTH INSURANCE

  The effect of AIDS on Health Insurance will be similar to death and disability benefits. However, the impact on Medical Aid schemes could be devastating. The cost of treatment of AIDS patients is exceptionally high. Figures of R2000 to R3000 per month are commonly quoted.

> 'An important area for union action is in medical aid schemes. Already many of the medical aid schemes have introduced very strict rules about paying for the treatment of AIDS. This is a very serious problem for anyone with AIDS because even though there is no cure, they need medical treatment... The problem is made worse because workers can't even rely on the state health services to look after them. Unions involved in medical aid schemes need to consider how they can negotiate for these rules to be improved. The other big problem is pensions...' (New Nation: 1990)

Therefore, the problems that AIDS poses for medical aid schemes and life insurance companies have begun to emerge. It is essential to debate and resolve these issues now, before the pattern of exclusion and discrimination, presently found in some medical aid and insurance policies, becomes entrenched.

4.4 General Preventative AIDS Education

Preventative AIDS Education is, at present, the only means of preventing the silent AIDS epidemic from developing into the threatened magnitude, great economic and employee benefit consequences, as discussed in 4.3 above.

4.4.1 AIDS and Past Sexually Transmitted Diseases

Since there is no simple answer to this health crisis, it seems logical that many have looked at the social history of efforts to control other sexually transmitted diseases (STDs), to establish their relevancy to AIDS (taking into account that the current epidemic is shaped by contemporary phenomena).

In a 1916 edition of the American Journal of Public Health, the Health Officer of Rochester, New York, Dr. Goller wrote: (Goller: 1916)

> 'From our limited knowledge of the subject, we are, therefore, to conclude that for the solution of the problem of prevention of venereal diseases there is but one recourse, and that is education. Not altogether that education which is to begin at the change of fourteen years or older, but that education which shall begin with the earliest lisp of the little child when it begins to ask the questions of the origin of its being..
>
> We must have educators for the people and for the physicians as well ... Who are we that we should judge the victim of venereal disease, innocent or guilty? ... Let us at least treat the patient as a man or woman and not deny him treatment and abuse him ...'

Dr. Goller's words can very well be applied to the public health problem of AIDS facing the world today.

In the 1500's, despite Church dominance, sexual freedom was generally tolerated. No stigma was attached to venereal disease and infections were not concealed. When a harsher code of morality came to prevail in the Victorian era, syphilis went underground. At the beginning of the 20th century, bringing syphilis into the open required considerable courage. This period witnessed considerable fear of STDs, not unlike that which we are experiencing today. Theories of casual transmission reflected deep cultural fears about disease and sexuality.

Despite the fact that AIDS exists in an era of sexual freedom, bitter controversies of how to deal with people with HIV, and whether to publicise preventative measures that advocate explicit types of sexual behaviour are raging. Additionally, persistent fears about casual transmission of AIDS are also rife:

Firstly, AIDS has heightened old hostilities towards homosexuality - it is strongly associated with behaviours which have been traditionally considered deviant. It is seen by some as "proof" of a certain moral order. Secondly, the discrimination against those with HIV, reveals the overwhelming fears surrounding the epidemic.

Therefore, according to Brandt (1988), the first lesson to learn from the history of STDs is that **fear** of disease will powerfully influence medical approaches and public health policy. That is, the primary aim of an AIDS prevention social marketing campaign should be to reduce such fears and create awareness of legitimate concerns.

The following discussion concerns **fear as a promotion tool of a social marketing programme.** The use of fear appeals in communication programmes is subject to much debate. This is primarily owing to the possible negative effects of anxiety stimulation.

Controversial questions which arise include:

- Is the use of fear appeals in marketing ethical?
- Is the use of fear appeals in marketing socially beneficial?
- How do such appeals affect the audience?
- Can such appeals be justified?

The aim of using fear appeals in communication programmes is usually to stimulate anxiety so as to prompt the audience to attempt to reduce anxiety by partaking in the desired behaviour or activity. Psychologists have shown that anxiety can be learned and appears to be easily conditionable. However, anxiety is highly complex and can be detrimental both to the individual and society. Therefore, more concern should be given to the ethical aspects of anxiety inducing messages. It is critical that consumer protection bodies scrutinise all such appeals carefully.

An example of where strong fear appeals were found to be less effective than mild fear appeals occurred in America in 1964 where, following the Attorney General's Report linking cigarette smoking to lung cancer, cigarette consumption briefly declined and then actually increased. A number of explanations have been offered for this phenomenon.

Firstly, strong fear appeals concerning a highly relevant topic (eg: a cigarette habit) cause the individual to experience cognitive dissonance, which can be resolved by rejecting the habit or rejecting the information. Secondly, since giving up any habit is not easy, consumers may reject the threat by denying the validity of the claims or believing they are immune to such harmful consequences. (Stuteville: 1970)

Therefore, an issue of critical importance is that of target market perceptions. Perception involves the process by which the individual selects stimuli into a meaningful and coherent picture. With respect to fear appeals, the "selection" process is most pertinent. This selection of stimuli from the environment is based on the interaction of many variables such as attitudes and expectations with the stimulus itself. Consumers often exhibit the following characteristics: They have a heightened awareness of stimuli that meet their needs or interests and a decreased awareness of stimuli irrelevant to their needs (selective attention). They actively seek out pleasant messages and actively avoid threatening ones (selective exposure). They protect themselves by simply blocking certain stimuli from conscious awareness (perceptual blocking). Therefore, perception theory is closely related to the effectiveness of fear appeals.

According to Ray and Wilkie, marketers seem content to ask the simple question: 'Is fear effective or not?' and to reach the premature conclusion that it is not effective as an appeal.

> 'There is now enough evidence from research and practical applications to indicate that fear should no longer be eliminated from consideration as a marketing and advertising appeal. The picture emerging from the more recent research on fear is that neither extremely strong nor very weak fear appeals are maximally effective. It seems that fear appeals at a somewhat moderate level of fear are best. A simple explanation for this might be that if an appeal is too weak it just does not attract enough attention. If it is too strong, on the other hand, it may lead people to avoid the message or ignore the message's recommendations as being inadequate to the task of eliminating the feared event.' (Ray and Wilkie: 1970)

Important Aspects of the Ray and Wilkie Study:

Ray and Wilkie examined two studies which obtained opposite results on fear. The Janis and Feshbach research on fear appeal and dental hygiene on high school students found the stronger the fear appeal, the less the response to dental hygiene. The Arkoff and Insko study on fear appeal and smoking (with respect to lung cancer) on seventh-grade students indicated that the high fear appeal was more effective than the low fear appeal.

The Janis and Feshbach curve decreases as the level of the fear appeal increases, that is, the acceptance of the message recommendations decline. On the contrary, the Insko et al curve increases as the level of the fear appeal increases, that is, the acceptance of the message recommendations rise.

This approach is extremely useful to marketers. Not only does it recognise the fact that the acceptance of fear appeals are specific to a target market, but that it is specific to the issue under discussion too. Additionally, Ray and Wilkie study the effect of fear on message exposure, learning and action. They find that while marketing has typically emphasised the potential inhibiting effects of fear motivation, fear research provides a number of hints for message construction which may lead to consumer action.

In conclusion, they found high fear appeals have worked best with people who are low in anxiety and high in self-esteem, who exhibit coping behaviour, who normally find the topic of low relevance, and who normally see themselves as having low vulnerability to the threat in the fear message. Therefore, fear appeals seem to be more effective in opening new segments than in selling old ones.

Thus, this study has highlighted a potentially powerful, largely neglected area in marketing. Ray and Wilkie have conducted a thorough, intensive investigation and have shown that contrary to previous thought, the fear appeal can help marketers in segmentation, communication goal setting, message construction, and product differentiation.

However, their treatment of the ethics of the issue seems both naive and incomplete:

> '... it seems likely that the level of fear that is effective in marketing would not be high enough to be even remotely unethical.' (Ray and Wilkie: 1970)

Is the Use of Fear Appeals in Social Marketing Justified?

Not only are fear appeals criticised because of the possible detrimental effects of anxiety stimulation, but also because often the solutions offered are inadequate.

> 'The issue of justification has largely been side-stepped in the marketing literature, perhaps because most research and discussion of fear appeals have centred around campaigns in which the communicator's goal has been to discourage smoking or encourage adoption of better health or safety practices. It is typically easier to achieve a consensus of favourable evaluation of communicators' goals in these cases than in those instances when a deodorant or cosmetic marketing application is being promoted.' (Spence and Monspour: 1972)

Better health and safety practices are certainly favourable, justifiable goals, however, this is not the issue at stake. The "end" is not being questioned here, rather the **means** to the end. Whether the use of fear appeals as a "means" is justified depends on the type of cause or idea, the situation and the target market. Only an in-depth study of these factors can determine whether the fear appeal is ethical, that is, whether it is beneficial to the individual and society as a whole.

The use of fear appeals in AIDS awareness campaigns is a highly sensitive issue. The following British advertisements were withdrawn soon after they were introduced:

1. An advertisement which showed a corpse wrapped up in a plastic bag labelled AIDS. (A body of someone who has died of AIDS is not handled like this.)
2. An advertisement which presented a mirror and read: 'Now you know what a typical AIDS carrier looks like.' One looked at the mirror and saw one's own reflection.

Thus, the AIDS situation 'can perhaps be summed up as one dominated by the fear of contagion and the contagion of fear'. (Metz and Malan: 1988) Therefore, if fear appeals are being considered in AIDS related situations, caution should be exercised.

This concludes the discussion on the use of fear appeals in a social marketing programme. The discussion on AIDS and past sexually transmitted diseases continues.

Early in the 20th century, physicians, public health officers and social reformers, concerned about venereal disease, called for the end to the "silence" - the belief that all discussion of sexuality and disease in a respectable society is inappropriate. The education programmes which followed emphasised the inherent dangers of all sexual activity. Margaret Cleaves, a leading social hygienist argued: 'There should be taught such disgust and dread of these conditions that naught would induce the seeking of a polluted source for the sake of a gratifying, controllable desire.' (Cleaves: 1910) However, these campaigns did not achieve the desired results.

According to Brandt (1988), the second lesson (see page 53 for first lesson) to be learned is that such misguided education will not control the AIDS epidemic. In fact, he states that these very educational campaigns may have actually contributed to the pervasive fears of infection, to the stigma associated with the diseases, and to the discrimination against its sufferers. However, he believes that as long as the fear approach is omitted, an AIDS education campaign can be effective provided it is 'explicit, focused and appropriately targeted at a range of "at risk social groups". If education is to have a positive impact, we need to be far more sophisticated, creative, and bold in devising and implementing programmes.' Therefore a social marketing as opposed to an ad hoc education programme is necessary.

Compulsory vaccinations and compulsory programmes for premarital syphilis serologies are probably the most widely known of all compulsory public health measures in the 20th century. Brandt found that the past has not only proved such measures ineffective but even counterproductive. (the third lesson)

The fourth lesson to be learned from the past is that the development of effective treatments and vaccines will not immediately or easily end the AIDS epidemic. In 1943 it was found that with a single shot of penicillin, the scourge of syphilis could be avoided. Despite this, the disease has persisted. Therefore, the development of an effective treatment without a continuing education campaign, may not prove to be a lasting cure. (By the late 1950's, most of the educational campaigns had been severely reduced. In 1987, the Centres for Disease Control reported an increase in cases of primary and secondary syphilis.)

Therefore, although the "magic cure" for AIDS has yet to be discovered, it is critical that we learn from the above lesson - how to use the cure should it be discovered.

Despite the fact that AIDS is different to STDs of the past and although there were no true social marketing campaigns then, as shown, there is much to be gained from experience. That is, despite many "superficial" differences, the underlying principles and phenomena are similar. To regard such a study as superfluous can be detrimental not only to the social marketing campaign, but to society as a whole.

4.4.2 Challenges Facing General Preventative AIDS Education

It is generally held that in the absence of a vaccine which could be many years away, effective health education is the best known method of curbing the transmission of AIDS.

> 'Health education and the dissemination of information on AIDS to the public... constitute an essential part of intervention.' (S.A. Advisory Group on AIDS: 1988)

> 'AIDS is already a significant event in South Africa and the only answer to it is education.' (Jack: 1991)

> '(An educational campaign)...is extremely high up on our (ANC) list of priorities.' (Valli: 1991)

There are many obstacles and challenges facing a Preventative AIDS Education Programme, worldwide and in South Africa:

WORLDWIDE

> 'The public response to AIDS has been one of fear, often reflected in excessive caution, discriminatory behaviour, and recommendations for drastic policy measures that are unwarranted in terms of what is known about the actual risk.' (Nelkin: 1987)

Legal and ethical dilemmas of the disease abound. For example, many doctors refuse to treat AIDS and HIV-antibody positive patients. What are the moral responsibilities of health care practitioners? Social factors which cannot be ignored include discrimination, stigmatisation and ostracism of certain groups. In our "enlightened" and "compassionate" society, many see AIDS as a just retribution for unacceptable behaviour. Additionally, AIDS is not only a highly traumatic disease, but has potentially severe political, economic and financial consequences.

It is wrong of heterosexual people to label AIDS as a gay disease. It is wrong for white people to say it is a black man's disease. **AIDS is what you do, not who you are.** In fact,

> 'From the substantial amount of epidemiological data on AIDS..., the conclusion can be made that the heterosexual transference of HIV from man to woman and from woman to man is by far the most common way of transmitting the disease... The spreading of the disease among homosexual men is now levelling off'. (RSA Policy Review: 1991)

External events influence responses to AIDS. For example, in the early 80's, newspapers labelled AIDS as a "gay plague". Resistance to behavioural change is often associated with a failure to perceive personal risk. (Some may believe AIDS to only be found among homosexuals.) Conflicting rumours or press reports may create confusion, and hinder people from seeing AIDS as being mainly a sexually transmitted disease against which it is easy to protect oneself. For example, incorrect suggestions that HIV can be spread through shaking hands makes the use of condoms seem pointless.

Adolescents who have several sexual partners in fairly rapid succession, may not perceive personal risk, because each relationship is considered faithful while it lasts.

According to Nicholas Freudenburg (AIDS Prevention in the **United States**: Lessons from the first decade: 1990):

> 'Education has provided accurate information on AIDS to a wide cross section of the population, but has been less successful in helping people to change their risk behaviour. Obstacles to effective AIDS prevention include: too great emphasis on information, a reliance on a one-way rather than interactive communication, a narrow categorical approach to AIDS; a failure to integrate prevention and treatment services, an unwillingness to acknowledge widespread distrust of government, scientists and health officials, and a focus on individual behaviour rather than social and political factors that shape behaviour.'

SOUTH AFRICA

The following highlights the politicised nature of the AIDS epidemic in South Africa:

> 'Right wingers perceived AIDS as divine intervention to stem the population flood, or as a weapon to harass returning exiles. They also warn the public in pamphlets that multiracial places such as schools, hotels, swimming pools and hospitals, as well as domestic workers, are AIDS threats.
>
> At the other end of the political spectrum, a 1988 edition of the African National Congress (ANC) Journal questions why a deadly virus should spring from nowhere, and points to the possibility of deadly viruses being developed in the secrecy of the laboratories of many imperialist countries...
>
> Probably none of these extraordinary outpourings represents the mainstream of conservative or ANC thinking, but they are useful pointers to the subterranean impact that AIDS has had and will have on politics, and are indicative of the enormous political sensitivity of the issue.' (Christie: 1991)

According to the April 1991 edition of Mayibuye, an official outlet of the ANC, the extent of the (AIDS) disease suggests that the ANC 'cannot wait for social reconstruction to be completed before starting a preventative programme'. The migrant labour system, poverty, homelessness, urbanisation, removals and violence increase the susceptibility of communities to AIDS.

> 'Education must be targeted at all levels, from activists to the community as a whole... We also recommend that the ANC national executive committee appoints a sub-committee on AIDS, and works closely with other bodies that are already working in the field.' (Nzo: 1991)

An HIV campaign must have the following features: (Draft Maputo Statement: 15/4/1990)

- It must be nonstigmatising and avoid stereotyping individuals and groups
- It must be founded upon community-based action. Political and other leadership must be involved
- It must identify and address the social and political factors relating to the spread of the disease

According to Dawn Mokhobo, a community affairs consultant (1990): Despite the effect of modern life on tribal customs, having multiple sexual partners is still the norm. Sexual excesses, especially those of males, are generally viewed as prestigious as they are seen to reinforce male supremacy and sexual prowess. Propaganda against multiple sexual partners in a society where this is the norm, rather than the exception, also militates against its acceptance and belief. Contraceptive practices are often viewed as the cause of venereal disease. Of all forms of contraception, condoms are the most unpopular as they

act as a barrier to physical contact. Additionally, contraception is often perceived as a white plot to limit normal black population growth and lessen political power. Homosexuality is largely non-existent, in the current day African society. Furthermore, the illness is unrelated to the sexual organs, and therefore represents a difficult concept to comprehend. It is difficult to understand how, because of the long latency period of AIDS, sex now could mean death from another symptom such as pneumonia in 10 years time.

> 'South Africa has faced a number of fairly unique problems in its (AIDS) education campaigns. Campaigns initiated by the Government have been criticised from both the right-wing and left-wing groupings.' (Sanlam: June 1991)

In the Finance Week, (August 3-9, 1989:14), the government's racially targeted mass media campaign is criticised for creating more confusion than clarity: Advertisements aimed at the black community featured a group of blacks around a coffin whereas the white "Kevin loves Janet" advert featured graffiti rather than people. This was interpreted among many blacks as meaning that AIDS kills blacks and is understood to have had a negative impact. It scared people and made them less receptive to further messages.

Therefore, the challenge facing a preventative AIDS education programme, worldwide and locally, is in **finding sensitive ways to promote "safe-sex" practices, and overcome fear and discrimination, within the legal, political, religious and moral constraints of a given culture.**

A South African AIDS education campaign faces additional, extremely challenging complications which call for careful well-planned and researched action.

4.5 AIDS Prevention in the Workplace

AIDS is rapidly becoming a significant workplace concern. Economic and financial implications of AIDS on the workplace include:

- loss of skilled manpower
- recruitment, screening and training of replacements
- disruption of the workplace and productivity loss
- legal and financial exposure
- direct and indirect health care costs
- disability and life insurance claims
- cost of educating management and employees - (i.e. companies should have a strategy for funding AIDS related education costs)

Berkley, in his article "AIDS in Sub-Saharan Africa" (1990), notes the following:

> 'HIV infection rates seem to peak in adults of reproductive age... Thus the bulk of AIDS morbidity and mortality will occur in the most economically productive age group...'

Workplace AIDS Education comprises: Education regarding AIDS-related Workplace Policies and Procedures. This includes: General AIDS Education - How to adopt preventative AIDS behaviour, counselling...

This dissertation concentrates on a Social Marketing Preventative AIDS Programme in the Workplace. AIDS has become an industrial relations issue. Employees fall into the reproductive age group and are therefore vulnerable to AIDS. This in turn adversely affects business in terms of loss of skilled manpower, decreased productivity, workplace disruption, higher

health care and employee benefit costs ... **It is therefore both in the interests of the employers and employees to exploit the organisational structure in order to engage in preventative AIDS programmes.** Such programmes would not only benefit the companies and employees concerned, but society as a whole.

The workplace is therefore a "strategic platform" for the development of AIDS-related Workplace Policies and Preventative AIDS Education Programmes.

There are four main participants. The discussion which follows introduces the "players" in the "AIDS in the Workplace" Environment:

a. EMPLOYEES

b. EMPLOYEE ORGANISATIONS

c. EMPLOYER OR MANAGEMENT

d. THE STATE

a. Employees with HIV:

These employees may be concerned with:

- The strict maintenance of confidentiality. Co-workers knowing that an employee is HIV-positive may lead to victimisation and intimidation to resign. Therefore, confidentiality of **all** medical information should be maintained.

- Not being permitted to continue working as before, not being treated in the same manner as employees with terminal illnesses such as cancer...

Employees Without HIV

These employees may either be tolerant or intolerant towards HIV-positive employees.

With respect to those employees who are intolerant:

- They may regard AIDS as self-inflicted.
- Despite education to the contrary, they may be concerned about becoming infected with the virus through casual contact in the workplace.
- They may be concerned about the cost of employees with HIV to the contributory health care funding schemes, and pension and provident funds.
- These employees may expect some protection against the HIV threat which they perceive. For example: The exclusion of HIV-positive people from the workplace.

b. Employee Organisations

The main concerns of employee organisations are to articulate the concerns of, and protect their members.

The protection of HIV-positive individuals may involve ensuring:

- no pre-employment HIV screening
- the employment of applicants with HIV
- no during employment testing
- non-discriminatory treatment of employees with HIV
- maintaining the confidentiality of an HIV-positive employee
- no victimisation of an employee with the virus
- continued employment until job performance is impaired
- medical benefits as for any other terminal illnesses.

An example of a conflict between management and unions is pre-employment screening: Systematically testing prospective employees for HIV infection. No employment offer is made to applicants who test HIV-positive. Many unions strongly object to the principle of pre-employment screening. Some employers have rejected these objections on the basis that prospective employees are not yet union members and therefore the unions are not representatives of the job applicants. (Researchers have focused on privacy rights of employees with respect to HIV testing, for example, Sing and Moodley: 1990. They emphasise a need for legislative measures that will guarantee protection of such personal information.)

Unions: The South African Environment:

Traditionally, health and safety issues have not featured high on the agenda of SA unions.

According to the editorial in Critical Health (1990):

> 'Managements' concern for the health and safety of workers is usually motivated by the wish to increase profit. Legislation around health and safety in South Africa is inadequate and operates largely in managements' favour.'

There is currently much debate over a possible model for post apartheid occupational health services.

In an article in Finance Week, the TGWU (Transport General Workers Union) general secretary Jane Barret said this of the AIDS problem:

> 'For the vast majority of union members, AIDS isn't believed to exist. Rather it's viewed as a propaganda plot devised by the government, supported by employers and pumped out by a restricted press to convince black people to have less sex and thereby fewer babies... The struggle for decent living wages and working conditions is so immediate and all-consuming for the average worker that the urgency is lost in dealing with a problem which has not yet manifested itself in an obvious way...' (Barret: 1989)

The above quotation reflects a situation which has only recently begun to change. The following discussion highlights what COSATU affiliated unions are doing with respect to AIDS: (The first public commitment by COSATU to dealing with the AIDS issue was in July 1989.)

The COSATU conference (July 1991), resolved that:

- COSATU campaigns for a national AIDS policy acceptable to all workers
- COSATU develops and implements an AIDS education project as a matter of urgency
- COSATU embarks on a programme of action to identify and eradicate those conditions which contribute to the spread of AIDS

The National Union of Mineworkers (NUM) have been at the forefront of union action against AIDS. As a mining union, NUM is concerned with the consequences of migrant labour and hostel life: They object to the belief that people with AIDS have themselves to blame for contracting the virus. They believe that the homeland policy, forced removals, labour migrancy, the hostel system and the black education system, have forced people to put up with circumstances where health depends on the position one holds in society.

They feel that it is the responsibility of unions to:

- inform their members about AIDS
- fight for job security, income security and medical benefits for those members who are HIV-positive
- fight for the eradication of those conditions which assist the spread of AIDS

NUM have undertaken an AIDS education programme. They have included a workshop on AIDS in their standard health and safety course, as well as a specific AIDS education project which will be taken to every mine or plant at which the union is organised.

NUM AIDS policy is based on the standards recommended by the World Health Organisation and the International Labour Organisation (see appendix B), with special reference to South Africa.

Therefore, NUM recognises that AIDS may assume epidemic proportions unless action is taken. They believe that **government, business** and **unions** all have crucial roles to play:

> 'Our success or failure ultimately depends on our ability to confront fundamental issues: employment policy and social policy. In the trade union movement, we believe that we have the will to do just this. Does the government and does business have the necessary will too?' (NUM: 1990)

NUM's message to employers is: The social context of AIDS cannot be ignored, the workplace is not separate from broader society and that employment policies need to reflect this.

The following examples highlight NUM's point of view: (NUM: 1990)

The provision and design of housing: Many employers are guilty of treating workers as single men or women when they are in fact married. Many workers who live on their employers' property are virtual prisoners and are not even allowed to have visitors. Therefore, employment conditions of this kind contribute to the break down of family life and encourage social relationships of a fleeting nature.

The inadequacy of public health services and the absence of social security in South Africa: This is one of the reasons why some employers discriminate against HIV-carriers and AIDS-sufferers. They want to make sure that they do not have to carry part of the social costs of AIDS, a situation which may well be unavoidable should a significant proportion of the workforce be affected. This approach is very shortsighted. Sooner or later the costs of AIDS will affect all sectors of our society. Ultimately employers will have to shoulder some of the costs and these costs will be greatly reduced if employers adopt humane work policies and play an active role in developing appropriate government policy with respect to health services and social benefits.

The TGWU has also been active with respect to the AIDS issue as the trucking industry involves long distances which people travel, and lengthy periods away from home.

They have undertaken an AIDS education programme: Shop stewards and line management drawn from branches throughout the country underwent a course to train them how to educate others about AIDS. The course was costly - over R1000 per person. According to Dlamini of the TGWU the programme was successful, despite being conducted by management, because the support of the union members was obtained. In order to put the course to good use, the union is turning to management to provide transport to the depots in the different regions. The TGWU have employed a person responsible for formulating an overall approach for dealing with the question of AIDS. They see the role of health and safety workers implementing the AIDS policy approach as crucial.

The following quotation depicts the (Transport General Workers Union) TGWU view of AIDS:

> 'The lead has to be taken by the trade union movement because the people we have in the trade union movement are some of the people who are threatened most directly by AIDS and at the same time the kind of material which has been made available by the government, for instance the kind of posters you see on notice boards in town, are of no use to them because many of them are illiterate. Essentially I think the unions need to move and move quickly in terms of creating awareness around AIDS.' (Dlamini: 1990)

c. Employers/Management:

Employers have the task of reconciling conflicting interests, and developing policies, procedures, and education programmes regarding AIDS and related workplace issues.

"AIDS in the Workplace" issues and challenges include the following options:

- Should there be HIV-antibody pre-employment screening?
- Should the confidentiality of HIV-positive employees be maintained?
- Should current employees be tested for AIDS?
- Should HIV-positive employees be allowed to continue working?
- Should disciplinary action be taken against co-workers who refuse to work with an HIV-positive employee?
- Should HIV-positive employees be excluded from benefits packages?
- What is the responsibility of the organisation towards its employees and the community?
- How should employees be educated with respect to preventative AIDS behaviour? ...

Although these AIDS-related problems have largely not manifested themselves as yet, **early action in order to prevent difficulties arising, is essential.** Furthermore, such action would serve to minimise the industrial relations and financial implications of "AIDS in the Workplace".

d. The State

The state is not directly concerned with AIDS in the Workplace. However, since "AIDS in the Workplace" is interlinked with "AIDS in the broader community", the actions by the government impact on the workplace.

> 'The South African government's response to AIDS first came to the fore towards the end of 1987 when it was announced that more than 1 000 infected migrant labourers would be deported, and that compulsory HIV screening for all black immigrant workers would be introduced before they were given contracts.' (Christie: 1991)

The government has set up AIDS Training and Information Counselling Centres, (ATICCS), throughout the country. The functions of the ATICCS include:

- To serve as a source of information
- To train trainers - public and private sector
- To counsel and train counsellors
- To get the community involved

> '...The Department of National Health and Population Development developed a draft strategy for the combatting of AIDS, of which various aspects have already been put into operation. The Government has also budgeted R8 million in the 1991/91 financial year for its direct educational AIDS programme. In October last year the Interdepartmental Committee for AIDS Prevention (ICA) was appointed to further, co-ordinate and evaluate AIDS prevention programmes on all levels in the public and private sector.' (RSA Policy Review: 1991)

Despite this, the government has been accused of not taking enough action to stop the spread of AIDS:

> 'A group of AIDS workers, angered by the alleged lack of support for AIDS care by National Health Minister Dr Rina Venter, held a protest in the city to publicise their feelings.' (Argus, July 30, 1991)

> According to ANC economist Mr Khetso Gordon, the government did not appear to be taking the AIDS problem seriously, as was demonstrated by the miniscule amount it budgeted to help slow down the spread of the disease. Only R1 million was allocated to the fight against AIDS in 1987 and R5 million for the 1991-1992 financial year. (Cape Times, May 1991)

The government has further been criticised by:

- The United States Secretary for Health, Dr Louis Sullivan: 'At present, SA is not doing enough about AIDS education.' (SAMJ: 1991)

Ivan Toms: "AIDS in South Africa: Potential Decimation on the Eve of Liberation" (1990), The government's overall response to AIDS has been unacceptable, and directed almost exclusively at whites. The AIDS advisory committee set up by the government, is unrepresentative. He argues that the credibility and legitimacy problems which the government has with the black community, will hamper an AIDS education programme. The National Progressive Primary Health Care Network is seen to play a key role in preventative AIDS education.

Mark Ellis: "AIDS: A Democratic Party Response" (1990), AIDS has continued to receive a low priority rating from the government.

HIV and AIDS in Southern Africa: Draft Maputo Statement (15/4/1990):

> 'The HIV campaign waged by the state has been grossly inadequate. Communities have not been involved, nor have representative organisations been consulted. Too few funds have been allocated to HIV prevention... The media and education campaigns have promoted fear, stigmatisation and discrimination... The South African state has not displayed any genuine commitment to dealing with the (AIDS) problem facing the population. We need to demand a set of demands directed at the state so that it does not neglect its responsibilities.'

> 'Government on the whole, has been very complacent in reacting to the AIDS scourge... The response by government to the AIDS epidemic has been totally inadequate... Alternatively, organisations like the ANC, South African Council of Churches (SACC), South African Black Social Workers Association (SABSWA) and Progressive Primary Health Care (PPHC) network, etc, are seen as being able to play a leading role' (Christie: 1991)

Despite the criticisms of government AIDS efforts, the socio-political, demographic and economic implications that AIDS may have on South Africa should inspire immediate co-operation and action. Therefore, both the public and private sectors have a vital role to play. The responsibility is clearly multidisciplinary and multisectoral.

Legal Issues

> 'At present the law (in South Africa) says little about HIV infection and AIDS. Parliament itself has not addressed the issue, nor are there currently any judgements of the civil courts or the industrial court dealing with HIV/AIDS. Apart from the two sets of regulations mentioned below (AIDS - a 'communicable disease' and 'Prohibited immigrants and employment in South Africa'), AIDS problems in the workplace therefore have to be addressed in terms of the general principles of existing law.' (Cameron: 1991)

According to Strauss (1988), the legal issues of handling AIDS in the workplace are still largely speculative. Strauss puts the following forward as statements that are tenable in his opinion.

1. If an employee is diagnosed as an AIDS virus carrier, the doctor who has made the diagnosis would not be entitled to inform his employer without the patient's consent. It may be justifiable, however, to notify the health care workers who will be required to attend to the patient.

2. An employer would not be entitled to dismiss an employee who is still capable of performing his occupational duties satisfactorily merely because of him being diagnosed as HIV-positive.

3. If an employee becomes disabled on account of AIDS, the employer may take steps to terminate his employment.

4. If fellow-employees refuse to work with an employee with AIDS, the employer should take reasonable steps to persuade employees that there is hardly any risk that the HIV virus may be communicated in the work situation as such. But if fellow-employees remain recalcitrant and an impossible situation is created for the employer, steps may be taken to terminate the employment of the infected employee.

5. If an employer were unilaterally to introduce an "AIDS termination clause" into the conditions of employment pertaining to persons presently employed by him, he may expose himself to an allegation of an unfair labour practice.

6. Should an employer terminate an employee's service prior to retirement age on the ground that he is physically incapable of performing his occupational duties, the normal rules relating to medical benefits and reduced benefits apply.

7. A fellow-employee is generally not entitled to refuse to work with a person who has been diagnosed as HIV-positive, and disciplinary action for misconduct may be taken against the former if he remains recalcitrant despite reasonable effort on the part of the employer to assuage his fears.

8. The situation of health-care workers is deserving of special attention. The employer must ensure that they are instructed how to avoid contracting HIV and he must provide them with equipment to ensure optimal safety in the handling of AIDS patients.

9. There is no duty on the part of the employee who has been diagnosed as HIV-positive to inform his employer of the fact. But once the employee's condition begins to deteriorate to the extent that he becomes unable to perform his duties adequately, a duty arises for him to inform the employer.

4.6 AIDS: A Just Cause For Social Marketing

This chapter has given an overview of: The Medical Facts about AIDS - emphasising the difference between HIV/AIDS, The Potential Impact of AIDS, **General Preventative AIDS Education**, and most important of all Challenges and Issues with respect to AIDS Prevention in the Workplace - the focus of this dissertation.

The literature on social marketing (chapters 2 and 3), provided a sound understanding of the principles behind, and elements of social marketing, as well as some practical, successful examples. The following definition was proposed:

> **Social Marketing is concerned with the goals of business and society. It is involved with matters of social concern - it is the marketing of social causes or programmes designed according to current identified and latent needs and wants of the target market(s).**

The examination of the literature and proposed definition of social marketing, and the issues and challenges surrounding AIDS Prevention in the Workplace, **show the need for the application of social marketing techniques to "AIDS Prevention in the Workplace".**

More specifically:

- **"Social Marketing is concerned with the goals of business and society. It is involved with matters of social concern..."**

Chapter 4 has clearly shown that AIDS is a social concern. By adopting **social marketing** preventative AIDS efforts in the workplace, companies will not only

serve their own interests, and the interests of their employees, but the long-term interests of society too: Social Marketing Workplace Preventative AIDS Efforts facilitate the **well-being of the company and employees** in terms of maximising productivity, minimising workplace disruption and discrimination, as well as promoting the adoption of preventative AIDS behaviour. This in turn contributes to the **economic and social well-being of society** as a whole.

- **"Social marketing is the marketing of social causes or programmes designed according to current identified and latent and wants of the target market(s)."**

Many international and local bodies (for example. WHO: 1988; IPM: 1989)), have responded to the challenges, issues and obstacles surrounding the impact of AIDS on the workplace, by recommending that companies undertake preventative AIDS efforts.

Based on the social marketing literature, it is proposed that social marketing techniques be applied to this "social cause/programme".

A **social marketing** Workplace AIDS Prevention Programme can achieve all that a workplace AIDS education programme per se can achieve, and more. It goes beyond the "one-sided", "teaching" approach. Such a campaign involves sophisticated market research, planning, manipulation of the "4 P's" and is a reciprocal, "exchange-oriented" relationship. This is necessary in order to induce cognitive, action, behavioural and value changes in the target market(s). (Kotler: 1980)

The target market may presently desire such a programme or may need to be educated as to the value of it. In order to execute such a campaign effectively, a strategic process should be undertaken. This process may provide the 'force', the 'direction' and the

'mechanism' as well as maximising 'adequacy and compatibility'; and minimising 'distance' (Wiebe: 1951) to further enhance the effectiveness of such a campaign.

Despite the fact that there is no empirical proof to show that such an AIDS programme is the "solution", this should not detract from its potential value. Rather, the fact that social marketing can be successfully applied to as complex and challenging an issue as family planning, (section 3.2), is encouraging.

Therefore, AIDS is certainly a just cause for social marketing.

4.7 Summary

AIDS is clearly a topical, pressing issue which features high on the agenda of many influential sectors in South Africa. Chapter 4 has briefly highlighted the grave consequences which this silent epidemic, is expected to have. It has proposed that social marketing applied to AIDS Prevention in the Workplace, is an effective means to overcoming the many challenges and obstacles which exist.

In the 80's, attention was focused on disseminating information about HIV/AIDS, and initiating programmes and policies. We are now at the beginning of the 90's, and it is essential to take stock of all that has been learned, assess current needs, and **implement action plans.** It is critical to direct all current and future efforts towards the challenges which face HIV/AIDS prevention.

There are no universal solutions to the critical issues, and education programmes, relating to **AIDS and the Workplace.** This dissertation aims to provide guidelines for the management of these issues by:

- Analysing what **South African** companies are doing with respect to AIDS, and,

- Investigating what preventative AIDS efforts the respondents consider practical to implement in their workplace.

Before discussing the results of this study, the research methodology shall be explained in detail.

CHAPTER FIVE

RESEARCH METHODOLOGY

5.1 Introduction

The scope, objectives and hypotheses of this dissertation are detailed in chapter 1.

In this chapter the research methodology is explained.

An exploratory research design has been adopted since 'exploratory research is appropriate to any problem about which little is known'. However, to the extent that there is 'no single procedure to follow' in developing a research design, and since a descriptive study 'rests on one or more specific hypotheses ... generally employs structured questionnaires (which) provides advantages in coding and tabulating ... (and) relies heavily on cross-tabulation analysis ...' (Churchill: 1987), this study appears to lie somewhere **along the continuum between exploratory and descriptive research.**

A **two-stage research approach** was adopted in order to investigate the problem.

5.2 Stage 1: Informal Research

This first stage falls within the realm of **exploratory research.** It involved:

a. Consulting current journals and appropriate books for relevant articles on:

- the social marketing concept
- social marketing and preventative health services
- AIDS-related Workplace issues

This provided a greater knowledge and understanding of the subject.

b. Unstructured interviews with:

- personnel concerned with AIDS in the workplace
- medical practitioners
- experts in the field of 'AIDS and employment' issues
- union representatives
- family planning staff
- speakers at 'AIDS in the workplace' conferences.

This informal research was not only a fact gathering exercise, but it provided substantial insight into AIDS-related workplace issues. It created a solid base for the questionnaire design, analysis of findings, conclusions and recommendations. Additionally, it strengthened the link between the social marketing concept and preventative AIDS provisions in the workplace.

5.3 Stage 2: Primary Research Design

The ideas and insights gained from the informal research discussed in section 5.2 provided valuable input into the second stage. The primary research design falls within the realm of **exploratory** and to a certain extent **descriptive research.** (as discussed in section 5.1) Furthermore, since the ultimate purpose of this study is to suggest social marketing guidelines to a preventative AIDS programme in the workplace, the research is of a **prescriptive** nature too.

In the field of psychometrics it is important to distinguish between information derived from an individual representing a company and the individual's personal opinion. This personal opinion may or may not reflect the views of the company concerned. This refers to the concept of validity.

Many experts in the field of pychometrics have interpreted the term "**validity**" differently. A common definition appears to be that validity refers to the extent to which a test or a set of operations measures what it is supposed to measure.

According to Ghiselli, Campbell and Zedeck (1981:266), a more recent, and perhaps better, definition is the "official" one given in the American Psychological Association, American Educational Research Association, National Council on Standards for Educational and Psychological Tests (1974): 'Validity refers to the appropriateness of inferences from test scores or other forms of assessment.'

In this study, a single respondent is identified who is believed to have knowledge of company practice and can therefore comment with confidence on certain aspects of the questionnaire. However, in other instances the nature of the question is such that only the respondent's personal opinion can be considered valid and an extrapolation of this as a reflection of company attitude should be treated with caution.

This section describes the sampling procedure, population, sampling frame and sample, questionnaire design and data analysis and explains how the literature survey and informal research contributed to the primary research design.

5.3.1 Sampling Procedure

After reviewing the various research methods available, it was decided to use a mail questionnaire to conduct the empirical element of this research. (The information required for this study is largely of a factual nature, and could be structured into a questionnaire format.)

The advantages and disadvantages of mail questionnaires have been discussed by many market research experts, for example Churchill: 1987, Weiers: 1984.).

The **limitations** of this technique include:

- Mail questionnaires afford the researcher little control in securing a response from the intended respondent
- Mail questionnaires do not allow the use of questions requiring extensive probes for a complete response
- A mail questionnaire affords little speed control
- The results can be biased by non-response. It is possible that the respondents who complete and return the questionnaire represent only one part of the population.

The **advantages** of this technique include:

- No interviewer bias
- Respondents are able to work at their own pace and therefore have more time to consider their responses
- Low cost relative to other methods such as personal interviews

In order to remove impediments to completion and improve response, the questionnaire was pretested. The pretest involved two stages: Firstly, despite mail survey being the chosen mode of administration, 10 personal interviews were undertaken by the author. These personal interviews provided an insight into how the questionnaire may perform under actual conditions of data collection. The pretest interviews were conducted among respondents similar to those being used in the actual study. A few minor changes were made.

The altered questionnaires were pretested a second time using a mail survey - the technique to be used for the full-scale study. The purpose of this second pretest was to uncover problems unique to the mail mode of administration. The questionnaire was sent to 15 respondents chosen as being typical of the defined sample population. Of the 15 questionnaires mailed, 10 were returned. The respondents were asked to comment on the questionnaire and say how long it took them to complete. The overall comment was positive: The questionnaire was considered clear and unambiguous. The respondents found the questionnaire a little long, (approximately 30 minutes to complete), but felt the urgent, pressing nature of the study compensated for this. The questionnaire was altered slightly. The new version was felt to elicit the information required. (The minor changes which were made are detailed in section 5.3.3)

A discussion of the **population**, **sample frame** and **sample** follows

5.3.2 Population, Sample Frame and Sample

AIDS prevention in the workplace can be undertaken by all organisations where the employer-employee relationship exists. For the purposes of this study the population of interest, is all companies as well as other institutions where the employer-employee relationship exists in South Africa. This is the population that, properly sampled would provide the most representative answers to the questions posed. This approach is constrained by both cost and time factors.

A number of mailing list options were explored. (For example the Johannesburg Stock Exchange List. This was rejected as it excludes all non-listed companies.) A list of the Institute of Personnel Management's (IPM) members was obtained and considered suitable. The reasons for this include: AIDS impacts on the area of human resources in an organisation. The implementation of an AIDS policy and education programme has generally been found to be the task of the personnel/human resources division. Furthermore, members of the IPM have had extensive exposure to information regarding AIDS-related workplace issues. (AIDS-related articles have been published in the IPM Journal, the IPM have formulated Workplace AIDS Prevention Guidelines for members, and IPM seminars/conferences on AIDS and the workplace have been held.) The members of the IPM therefore represent the body most likely to be knowledgeable regarding AIDS and related workplace issues. This list formed the sampling frame for the quantitative stage of the study. The IPM list comprised members of both "large" and "small" companies from a variety of different industries. This list was handsorted and companies that were not based in South Africa, or appeared on the list more than once were excluded. Additionally a number of private individuals who appeared on the list were omitted.

It was decided to take a probability sample from each group. A systematic sample was utilised which involved selecting every k^{th} element after a random start. This sampling method was used as it is one of the less complex methods of sampling a population of interest, and it provided a **representative** sample with a **reasonable cross-section of companies.**

When sending questionnaires to organisations, a 20% response rate can be expected (Rawnsley: 1978). It was therefore decided to send 600 questionnaires. The sample size was thus set at 600 organisations.

Questionnaires were posted together with a covering letter (see appendix A) and an addressed envelope. The first questionnaire began returning one week after posting. The total response rate was 49% (294 companies). 284 of the 294 questionnaires returned were suitable for statistical use. Thus the functional response rate was 47%.

5.3.3 Questionnaire Design

Many market researchers have listed techniques which are believed to improve the response rate of mail questionnaires. This questionnaire attempted to incorporate the techniques which appeared feasible. Thee reasons for some of the techniques not being feasible are cost related. For example, no reward or incentive was offered to respondents and there was no follow-up reminder to non-respondents. (Fortunately, this was not essential owing to the 47% response rate.)

According to New (1989), the response rates to a mail survey will be increased when:

a. the research will benefit the community or economy
b. the response will contribute to the success of the study
c. there is support by a university
d. the appeal flatters the recipient

Accordingly, the covering letter (see appendix A) was carefully designed so as to incorporate these four requirements:

- The letter was on a University of Cape Town, Department of Business Science letterhead. (requirement (c))
- The letter emphasised the value of the research to the body of knowledge available on "AIDS in the Workplace" and the deep insight it can offer into current problems and policy solutions. (requirements (a) and (b))
- The contribution of each respondent was stressed: "Your commitment and participation is extremely highly valued". (requirements (b) and (d)).

In addition to this:

- Confidentiality was stressed
- A "free post" envelope was included
- The respondents were asked to endeavour to return the questionnaire by the deadline date. (The deadline date was set at approximately three weeks after postage.)

According to Weiers (1984), a mail questionnaire must be made attractive to the potential respondent, and appear simple and not too time-consuming to complete. The questionnaire was designed to comply with these requirements. (see appendix A)

A structured, undisguised questionnaire was designed in order to obtain the information requested. Almost all the questions were fixed-alternative questions. Open-ended questions were avoided with the exception of: the demographics section (industry category, position of respondent, number of employees in the company), question 27 - which external organisations assisted the AIDS education programmes, and the "other category". The latter was

included in the majority of the fixed-alternative questions in order to avoid forcing a response to a question on which the respondent did not have an opinion or forcing a response to fit a fixed alternative.

The literature review and especially the informal research and pilot tests were thus critical in ensuring that the alternatives adequately covered the range of possible replies and were mutually exclusive and unambiguous.

The questions were simply phrased to ensure understanding. Ambiguity and leading questions were avoided. The sequence of the questionnaire was structured to be tension reducing with stressful questions surrounded by factual ones.

The questionnaire is structured in the following way:

There are **two broad sections** which consist of a number of sub-sections. Section 1 relates to the first part of the overall research objective (1.3.1 (i)). Section 2 relates to the second part of the overall research objective. (1.3.1 (ii)).

Section 1 of the Questionnaire

Section 1 involves an investigation into the provisions which have been made for AIDS in the companies in the sample. The questions are mainly multichotomous and dichotomous questions. They are based on the findings of the preliminary research as well as the literature review. The questionnaire is largely self- explanatory, however, the construction shall be discussed in more detail:

a) Section 1 is divided into seven headings which followed naturally from the main and sub objectives of the study (sections 1.3.2, 1.3.3).

b) Not all the questions were compulsory since many were not applicable to certain companies. For example, if a company had no organised preventative AIDS education, questions 25 - 33 would be skipped as they refer only to those companies which do have organised AIDS education. Furthermore, some respondents did not answer every question. (This explains why the sample size is not 284 for every question.)

c) The respondents were asked to "rank in order of importance" in questions 14, 28 and 29 in order to provide a greater insight into the options listed in each question.

d) Where necessary (as highlighted by the pilot study), examples were given to clarify certain concepts. For example, question 7 reads, ...'any life-threatening disease (eg: cancer)...'

e) Questions 4, 5, 12, 14, 16, 18, 19, 20, 21, 26, 27, 28, 29, 30, 31, 32, 36, 38, 40 may all have more than one response.

f) The pilot test revealed that: in Question 17, a distinction should be made between **formal** (written) AIDS policies, and **informal** AIDS policies; in Question 24 "**only posters/pamphlets**" should be not be classified under "ongoing" or "once-off" AIDS education.

In retrospect, there are two areas of the questionnaire where errors, not identified by the pilot study, have been identified: Firstly, the inclusion of the "unsure" option in Questions 12 and 14 which are of a multiple response nature. These results should therefore be interpreted with care. Secondly, the use of the term "workshops" in Question 24 and Questions 28 and 29. This is a potential area of confusion and the results should therefore be interpreted with care. This is discussed in more detail in the respective sections.

Section 2 of the Questionnaire

Section 2 involves an investigation into the preventative AIDS provisions which the respondents from the companies consider practical to implement in their workplace.

This investigation was triggered by:

- The lack of empirical evidence on the preventative AIDS provisions which companies in South Africa consider **practical** to implement in their workplace. (The informal research identified this.)

- The realisation of the value of, and need for such research. (The informal research identified this too.) This dissertation would go a step further than identifying the "status quo" of AIDS-related workplace efforts in South Africa. It would demonstrate the AIDS provisions which the respondents from the companies consider practical to implement in their workplace. Together, the results of the two sections facilitate greater insight and understanding, than the results of section 1 alone.

The questions are based on the findings of the preliminary research as well as the literature review. The questions are largely self-explanatory, however, the construction shall be discussed in more detail:

a) There are five subsections which are based on the main and sub hypotheses (sections 1.3.4, 1.3.5). Each subsection comprises a number of statements.

b) A five point scale was used. The respondents were asked to respond "Highly Practical", "Practical", "Unsure", "Impractical" or "Highly Impractical" to the series of statements.

c) The Preventative AIDS Education section comprises a number of statements which are repeated under the headings of a "Management AIDS Education Programme", an "Employee Representative AIDS Education Programme" and an "Employee AIDS Education Programme". The pilot test indicated that different education programmes may be required for the three groups above. These questions were designed in order to determine whether this was necessary.

d) The final page of the questionnaire consists of three questions containing a number of options. It requires the respondents to rank each set of options first "in order of importance", and second "in order of practicality". The aim of these questions was to provide a greater insight into the options listed in each of the three questions.

5.4 Data Preparation and Analysis

Once the questionnaires were completed and coded, they were examined for errors and inconsistencies.

This study used the **Lotus** software package to enter the data and the **Statgraphics** software package to analyse the data according to frequency distributions (in the form of histograms) and crosstabulations. ('Crosstabulation involves the examination of data for two or more variables simultaneously and allows relationships among and between those variables to be measured.') (Churchill: 1987)

5.5 Summary

A mail questionnaire was designed in order to achieve the overall research objective of this study. The questionnaire was designed for ease of completion. The response was satisfactory.

The research process has been reduced to its components so that the issues which arise at each stage can be highlighted. These components together form an integrated, cohesive whole with each stage being interrelated and interdependent.

The problem has been formulated (Chapter 1), the literature discussed (Chapters 2, 3 and 4), and the research methodology explained. (Chapter 5). The research findings, discussions and conclusions (Chapters 6 and 7) follow logically.

CHAPTER SIX

RESEARCH FINDINGS AND DISCUSSIONS

6.1 Introduction

The aim of this chapter is to establish what **preventative AIDS provisions the companies in the sample as perceived by the respondents are undertaking.** Where possible, **the literature and the interviews held during the informal research will be utilised to elaborate on the empirical findings.**

Chapter 6 involves an analysis of the responses to section 1 of the questionnaire. Some questions require the respondents to describe company practice, while others require a personal opinion on a particular issue. With respect to company practice, it is assumed that the respondents can speak with confidence regarding their company's AIDS efforts for two main reasons. Firstly, all respondents are members of the Institute of Personnel Management (IPM). The IPM, through their channels of communication (for example: The IPM Journal, Guidelines on AIDS Prevention circulated to members, Conferences for members and the public), have exposed their members to the facts and dilemmas surrounding AIDS prevention in the workplace. Secondly, the majority of the respondents (63%) are involved with personnel/human resources in their companies. The informal research has shown that AIDS prevention in the workplace is mostly personnel/human resources driven. With respect to the personal opinion of the respondents, this may or may not represent the views of the company concerned. The discussion will highlight where this occurs. Furthermore, the discussion is based on the findings which emerge from an analysis of the questionnaire, and augmented by information obtained by the author in group discussions with opinion leaders in AIDS-related fields.

This chapter will present the research findings which are discussed in terms of the primary and secondary problems as stated in chapter 1 (1.3.1). A brief **"Profile"** of the companies in the sample is discussed (6.2). The companies' actions with respect to an **AIDS Policy** (6.3) and **AIDS Education** (6.4) are investigated.

The **Recruitment and Selection Policies** with respect to HIV-positive applicants (6.5), and **Procedures Regarding Current Employees with the HIV virus**, (6.6), are examined in order to provide a more detailed understanding of the AIDS Policy approach. The **Effect** which AIDS is expected to have on the companies (6.7), the **Level of AIDS Awareness** in the companies (6.8), and the **Willingness to Further Preventative AIDS Efforts** (6.9), offer an understanding of the companies' stance as perceived by the respondents regarding AIDS and related workplace issues.

6.2 Profile of the Companies

a. Industry Category

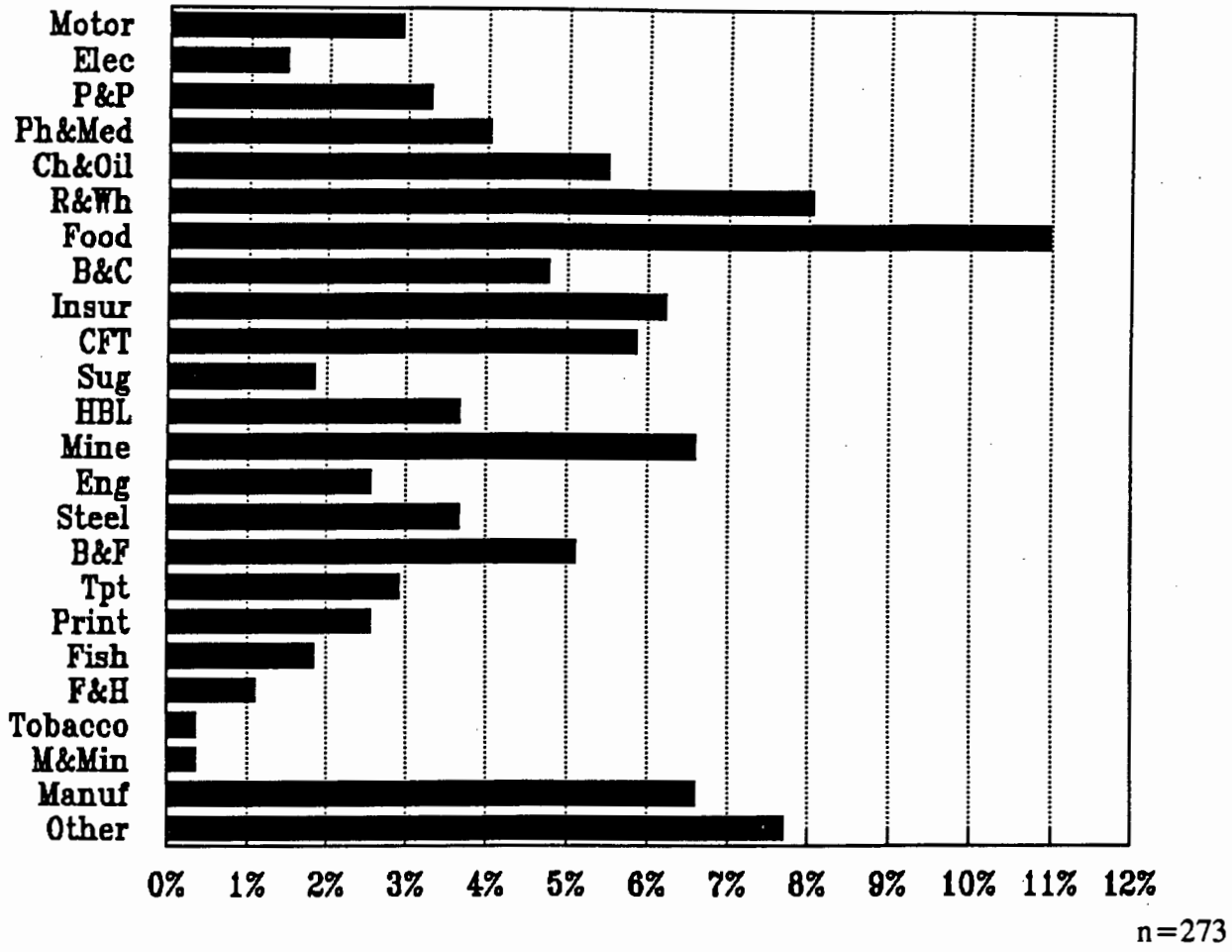


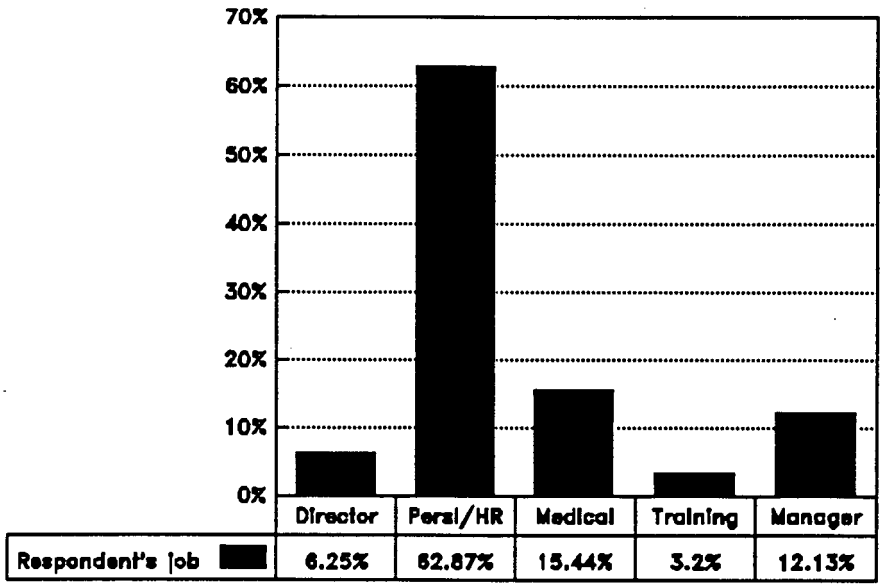
FIGURE 1: THE COMPANIES IN THE SAMPLE ACCORDING TO INDUSTRY CATEGORY

Key of Abbreviations:

Elec	= Electronics	Mine	= Mining
P & P	= Paper and Packaging	Eng	= Engineering
Ph&Med	= Pharmaceutical and Medical	B&F	= Bank & Finance
Ch&Oil	= Chemical and Oil	Tpt	= Transport
R&Wh	= Retail and Wholesale	Print	= Printing & Publishing
B&C	= Building and Construction	Fish	= Fishing
Insur	= Insurance	F&H	= Furniture & Household
CFT	= Clothing,Footwear,Textiles	M&Min	=Metal,Minerals
Sug	= Sugar	Manuf	= Manufacturing
HBL	= Hotel, Beverage, Liquor		

Figure 1 shows the companies in the sample according to **industry category.** As can be seen, there is no industry category which dominates: The industry to which the most companies belong to is "Food" (10.98%). The companies in the sample therefore represent a wide cross-section of industries in South Africa. (The industry type (Question 1) was open-ended and post-coded according to the Johannesburg Stock Exchange Classifications. There are two exceptions: The nature of the responses demanded an "Other" category and some companies responded simply by answering "Manufacturing".

b. Profile of Respondents with respect to Job Category



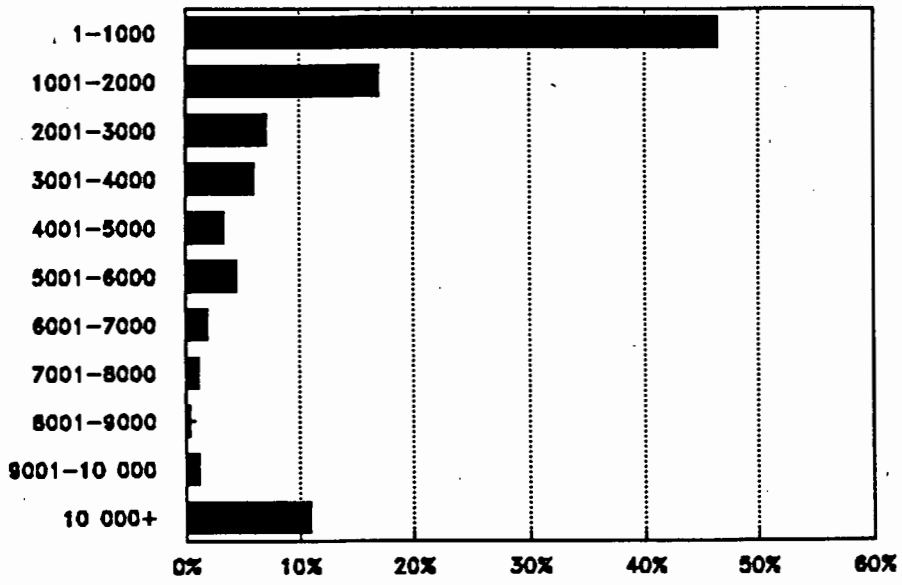
n=272

FIGURE 2: PROFILE OF RESPONDENTS ACCORDING TO JOB CATEGORY

Figure 2 shows the area in the companies in which the respondents work. The majority of the respondents are from personnel/human resources (62.87%). To a far lesser extent, the respondents are occupational

health/medical people (15.44%) and "managers" (12.12%). The minority of the respondents are general managers or directors (6.25%), or are in the area of "training" (3.32%).

c. Number of Employees

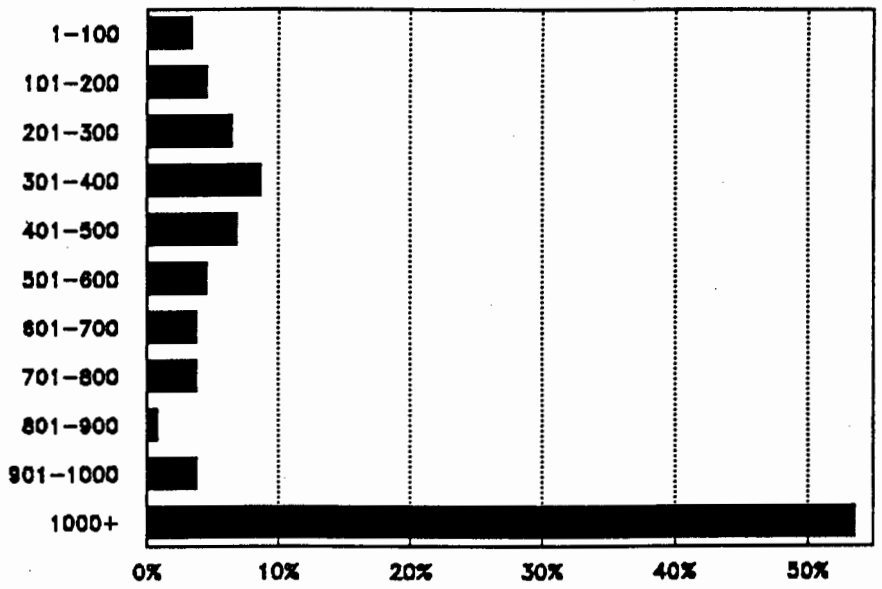


n=265

FIGURE 3: NUMBER OF EMPLOYEES IN THE COMPANIES (intervals of 1000)

Figure 3 shows the profile of the companies in terms of size. 46.42% of the companies have less than 1000 employees. (53.58% have greater than 1000 employees.) There is not a big discrepancy between the number of companies in the sample which have **less than 1000 employees** and **more than 1000 employees.** The responses to the questionnaire should therefore be representative of the views of companies with greater than 1000 employees and less than 1000 employees. .

Of the companies which have **more than 1000 employees**, Figure 3 indicates that: The "1001-2000" interval received the strongest response (16.98%), the "10 000+" interval was next (10.94%). The balance of the responses which fall into the intervals between 2001 and 10 000, do not exceed 7.3% for any particular interval.



n=265

FIGURE 4: NUMBER OF EMPLOYEES IN THE COMPANIES (intervals of 100)

The purpose of Figure 4 is to provide a more detailed view of the companies with **less than 1000 employees**: There is no interval that has the majority of responses. The "301-400" interval received the strongest response (8.68%), closely followed by the "401-500" (6.79%) and "201-300" (6.42%) intervals. The rest of the intervals each received less than a 4.6% response. Therefore, Figures 7 and 8 have shown that within the **"less than 1000 employees"** and **"more than 1000 employees"** categories, the responses are varied.

Summary

From Figures 1, 3 and 4 it can be seen that the sample represents a wide spectrum of companies of **different sizes and belonging to a variety of industries.** The areas in which the respondents work - mainly personnel/ human resources should facilitate knowledgeable responses to the questionnaire as: AIDS impacts on the area of human resources and the informal research and empirical findings (7.2(a) and 7.3(a)) have shown that the respondents from the companies consider it practical to involve personnel/human resources in their preventative AIDS efforts.

6.3 Findings: AIDS and Company Policy

The purpose of this section is:

(a) **To establish**

- Whether the companies have **formal** or **informal** AIDS policies, and the reason for **no AIDS policy**
- **How** the AIDS policies were **formulated**
- **Who** was **involved** in the policy formulation
- **How** the AIDS policies are **communicated**

(see appendix A: Questions 17-22)

(b) To gain a **greater insight** into the companies with formal AIDS policies, informal AIDS policies and no AIDS policies.

This is achieved through crosstabulations of Question 17 (What provision is made for AIDS in company policy - **formal**, **informal** or **none** at all?) with various other relevant questions:

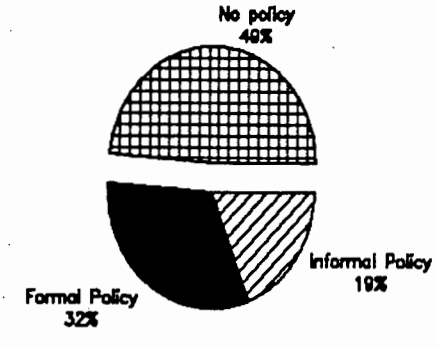
- The **size** of the company
- The expected **impact** of AIDS on the company
- The volume of preventative AIDS **education**
- The **approach** towards suitable applicants with the HIV virus, and
- The **willingness** to devote further resources to AIDS prevention

(see appendix A: Questions 3,7,8,14,15,24,34)

(c) In this section, some questions required the respondents to report on company practice, while others required them to express their personal opinion. The latter responses will be highlighted.

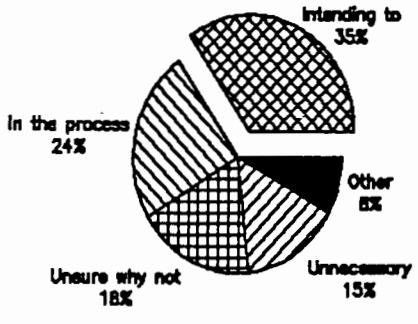
(a)

(i) The Type of AIDS Policy and Reasons for No Policy
(see appendix A: Questions 17, 22)



n=283

FIGURE 5



n=138

FIGURE 6

FIGURE 5: TYPE OF AIDS POLICY
FIGURE 6: REASONS FOR NO AIDS POLICY

Figure 5 above shows that 32.2% of the companies in the sample have **formal** AIDS policies and 19% have **informal** AIDS policies. Therefore, 51.3% of the companies **have** made provision for AIDS in their company policy. This is in line with the WHO recommendation that 'such policies be developed and implemented before HIV-related questions arise in the workplace.' (WHO: 1988)

48.8% of the companies have **no** AIDS policy at all.

The responses to Question 22 ("Reasons for no AIDS policy"), reflect the opinions of the respondents.

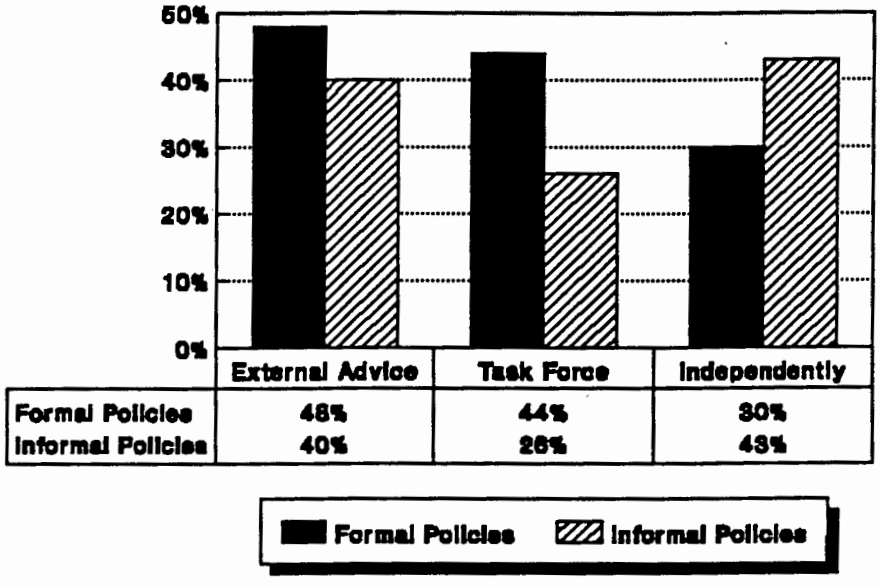
Figure 6 above indicates the **reasons** for not having an AIDS policy. They include: "intending to make such provisions shortly" (34.8%), and "in the process of formulating such a policy" (23.9%). To a lesser extent, the respondents are unsure why they have no policy (18.1%), and such provisions are considered unnecessary. (15.2%).

(The options in Question 22 are mutually exclusive. The "unsure" option reflects the respondents' doubt.)

With respect to the companies which **have formal and informal AIDS policies:**

(ii) How the AIDS Policies Were Formulated

(see appendix A: Question 18)



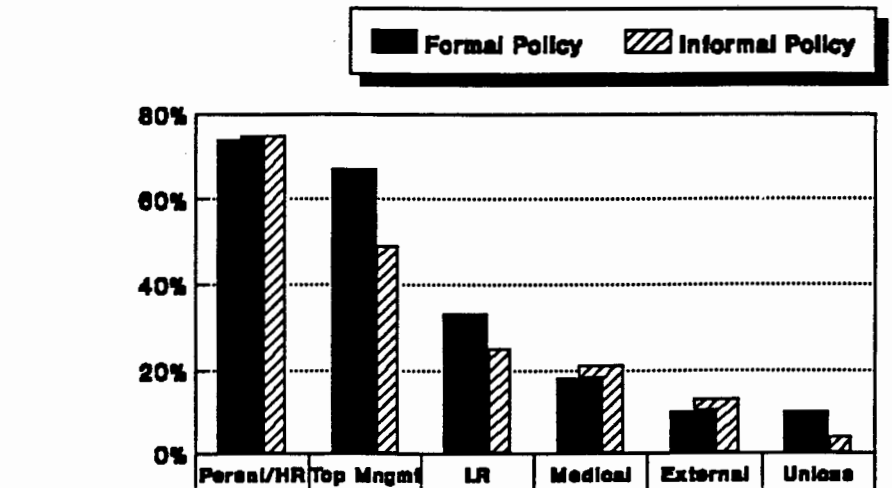
n=144

FIGURE 7: HOW THE AIDS POLICIES WERE FORMULATED

Figure 7 shows the way in which the formal and informal AIDS policies were formulated. The **formal policies** were mostly formulated by obtaining advice from **external bodies** (48%), appointing a **task force** (44%), and independently (30%). Less companies with **informal policies** appointed task forces (26%), while more did it independently (43%). 40% of the companies with informal policies approached external bodies.

(iii) Involvement in the AIDS Policy Formulation

(refer to appendix A: Question 19)



	Personl/HR	Top Mngmt	LR	Medical	External	Unions
Formal Policy	74%	67%	33%	18%	10%	10%
Informal Policy	75%	49%	25%	21%	13%	4%

n=144

FIGURE 8: WHO WAS INVOLVED IN THE AIDS POLICY FORMULATION

From Figure 8, it can be seen that most involved in the **formal** policy formulation were **personnel/human resource** department (74%) and **top management** (67%). The importance of top management and human resources involvement is

emphasised by the Institute of Personnel Management (IPM: 1988) To a lesser extent, industrial relations department (33%), and medical staff (18%) were involved. A minority involved external organisations and unions. The latter is in conflict with the views of the National Union of Mineworkers (NUM) that unions have a critical role to play in formulating an effective company policy on AIDS. (NUM: 1989)

Most involved in the **informal** policy formulation were **personnel/human resources** (75%). Figure 12 illustrates that the informal policy formulation involved far **less** top management involvement (49%), and slightly **more** personnel/human resources, medical and external involvement than the formal policy formulation.

A crosstabulation was conducted on Question 19: "Who was most involved in formulating the AIDS policy?" in order to establish to what extent a **multidisciplinary approach** was utilised. (This applies to formal and informal policies.) (see appendix F)

	Persl /HR	**I.R.**	**Unions**	**Extn Body**	**Medical**
Top Mngmt	**77.0%**	36.8%	**10.3%**	10.3%	16.1%
Persl H.R/		33.6%	**9.3%**	8.4%	15.9%
I.R.			20.9%	11.6%	23.3%

n=144

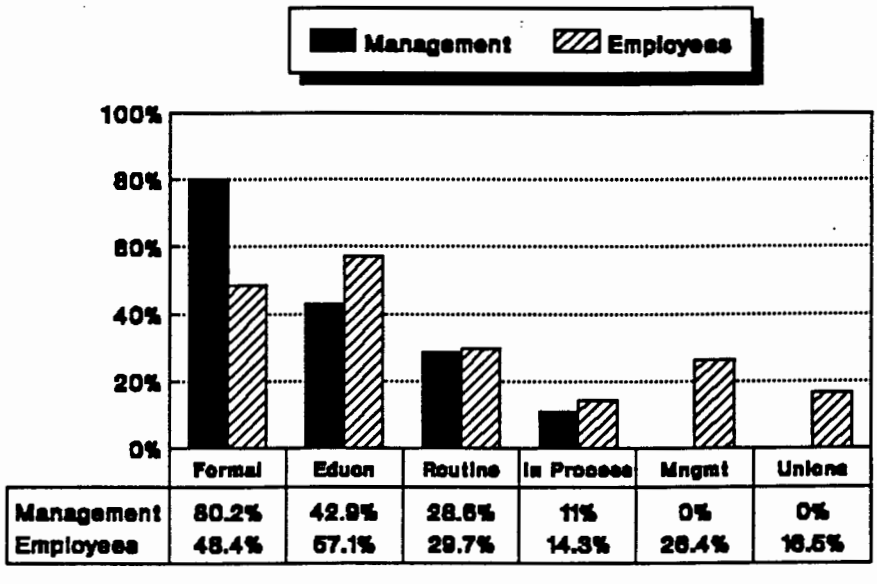
TABLE 3: CONSULTATION BETWEEN THE DIFFERENT SPHERES OF THE COMPANIES IN THE AIDS POLICY FORMULATION

Table 3 was drawn up from the crosstabulation conducted on Question 19 (see appendix F for the **separate crosstabulations** which are **summarised** in the table above.)

and shows that there were varying degrees of consultation with the different spheres of the organisation: For example: When **top management** were involved, this was mostly in conjunction with the **personnel/human resources** department (77.0%), although other spheres such as industrial relations (36.8%), were involved to a lesser extent too. The multidisciplinary approach to policy formulation supports the proposition (Allensworth and Symons: 1989) that there should be an involvement from all spheres of the organisation in policy formulation. There appears to be very little consultation between **unions** and top management (10.3%), personnel/human resources (9.3%), occurred in the policy formulation. This action is contrary to the view that 'the lead has to be taken by the trade union movement...(as) the people... in the trade union movement are some of the people who are threatened most directly by AIDS...' (Dlamini: 1990)

(iv) How the AIDS Policy is Communicated:

(see appendix A: Questions 20,21)



n=144

FIGURE 9: MEANS OF COMMUNICATING THE **FORMAL** POLICY TO MANAGEMENT AND EMPLOYEES

Figure 9 shows that the prime means of communicating the **formal** AIDS policies to **management** is through **formal policy channels** (those mediums used for all policy communication) (80.2%), **education** (seminars/courses) (42.9%), and routine activities (meetings/newsletters) (28.6%). A minority are in the process of formulating how to do so. (11%)

The prime means of communicating the **formal** policy to **employees** is through **education** (57.1%), **formal policy channels** (48.4%), and routine activities (29.7%). To a lesser extent, management/supervisors (26.4%) and unions (16.5%) are utilised. A minority are in the process of formulating how to do so (14.3%).

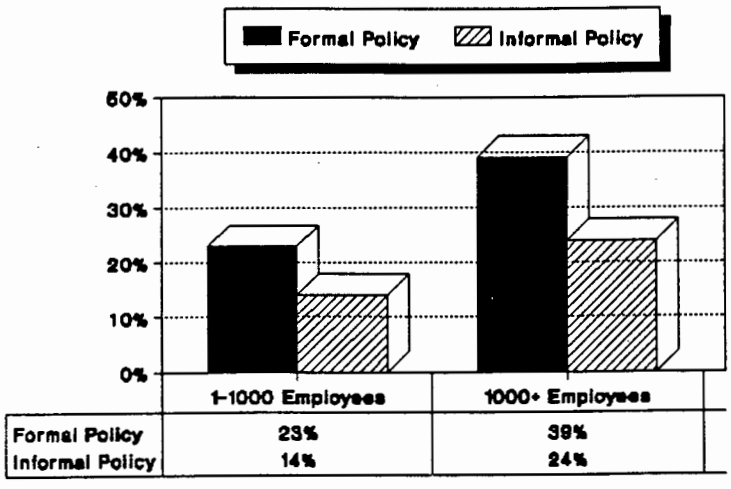
Approximately half of the companies with **informal** policies are **in the process of formulating how to communicate** their AIDS policies.

(b)

In order to gain greater insight into the companies, a series of crosstabulations were conducted on Question 17 (**whether the companies have a formal/informal policy or none at all**) and various other relevant questions. (See appendix A: Questions: 3,14,15,24,7,8,34). The individual, complete crosstabulations are shown in appendices G to P. The figures and tables which follow are derived from these crosstabulations.

The following findings emerged:

(i) Size: (see appendix G)



n=264

FIGURE 10: SIZE OF THE COMPANY AND AIDS POLICY APPROACH

Figure 10 shows that more companies with **greater than 1000** employees have AIDS policies (formal (39%) and informal (24%)), than those with **less than 1000** employees (formal policy (23%), informal policy (14%)).

(ii) Impact:

Table 4 is derived from crosstabulations which are shown in appendices H to L.

Appendix:	H	I	J	K	L
	Impact of AIDS now "None"	**Impact of AIDS 5 years "None"**	**Decrease Product-ivity**	**Very Costly**	**Disrupt Conduct Business**
FORMAL POLICY	50.5%	3.3%	82.4%	72.5%	56.0%
INFORMAL POLICY	50.0%	1.9%	77.8%	55.6%	37.0%
NO POLICY	47.1%	2.9%	66.9%	44.9%	50.0%

n=281

TABLE 4: TYPE OF AIDS POLICY AND EXPECTED IMPACT OF AIDS ON THE COMPANIES

The expected impact of AIDS on the companies requires the respondents to express a personal opinion.

Table 4 shows that 50% of the respondents from companies which **have an AIDS policy** (formal or informal) believe that currently AIDS has **no impact** on their company. An absolute minority of the respondents expect AIDS to have no impact on their companies in five years time. (formal: 3.3%; informal: 1.9%)

These findings are very similar to those respondents from companies with **no AIDS policies.**

An overwhelming majority of the respondents from companies **with AIDS policies**, believe that AIDS will affect their company, particularly in terms of "**decreased productivity**" (formal: 82.4%; informal: 77.8%), (eg: increased absenteeism/shortage skilled manpower). They also expect the impact of AIDS to be **very costly**, (formal: 72.5%; informal: 55.6%), and to a lesser extent **disrupt the conduct of business** (formal: 56%; informal: 37%).

(iii) Preventative AIDS Education

Table 5 is derived from crosstabulations which are shown in appendices M to N.

Appendix: M N

	Organised AIDS Education	
	- Mngmt	Employees
Formal Policy	75.9%	85.7%
Informal Policy	51.9%	57.4%
No Policy	26.1%	33.3%

n=283

TABLE 5: TYPE OF AIDS POLICY AND ORGANISED PREVENTATIVE AIDS EDUCATION FOR MANAGEMENT AND EMPLOYEES

Table 5 shows that the majority of the companies with **formal AIDS policies** have **organised preventative AIDS education** (see Glossary for definition) for management (75.9%) and employees (85.7%). (A minority of these companies have no AIDS education at all: management 14%; employees 10%)

With respect to the companies with **informal policies**, just over half have organised AIDS education for management (51.9%) and employees (57.4%). (A significant number of these companies have no AIDS education at all - management 30%; employees 20%.)

The companies with **no AIDS policies** have far less organised AIDS education (management 26.1%; employees 33.3%). (20% of these companies have "only posters/ pamphlets".)

It appears that a common trend amongst the companies with and without AIDS policies, is that **management receives less education than employees.**

(iv) Approach to Suitable Applicants with the HIV virus:

	Formal Policy	Informal Policy	No Policy
No Policy, Usually Turn Away	**14.3%**	**37.0%**	**33.3%**
No Policy, Circumstances	**20.9%**	**37.0%**	**31.2%**
No Policy, Does Not Matter	0.0%	0.0%	0.0%
Policy: Employ With No Provisos	8.8%	0%	2.2%
Policy: Employ With Provisos	12.1%	3.7%	3.6%
Policy: Not To Employ	**35.2%**	11.1%	8.0%
Unsure	8.8%	11.1%	**21.7%**
	100%	100%	100%

n=283

TABLE 6: TYPE OF AIDS POLICY AND APPROACH TO EMPLOYING HIV-POSITIVE APPLICANTS

The recruitment and selection procedures with respect to applicants with HIV and those with general life-threatening diseases, may require the respondents to express a personal opinion - especially where the company concerned is considered to have no formal policy regarding this issue.

From Table 6 (see appendix O) it would appear that the respondents from the companies with **AIDS policies** do not exhibit a consistent approach regarding the employment of suitable applicants with the HIV virus:

The strongest response from the respondents from companies with **formal** policies is "policy not to employ" (35.2%). 20.9% responded "no policy, depends on circumstances", and 14.3% have "no policy, but would usually turn away".

The strongest responses from the respondents from companies with **informal** policies and **no** policies are "no policy, but would usually turn away", (informal policy: 37%; no policy: 33.3%), and "no policy, depends on circumstances". (informal policy: 37%; no policy: 31.2%)

It appears that the respondents from companies with **no AIDS policy** are the most unsure of their employment procedure regarding an applicant with the HIV virus (21.7%).

(v) Willingness to Further AIDS Efforts Internally:

	Formal Policy	Informal Policy	No Policy
WILLING TO INCREASE EFFORTS AGAINST AIDS IN THE WORKPLACE	**96.6%**	**86.8%**	**80.6%**

n=274

TABLE 7: TYPE OF AIDS POLICY AND WILLINGNESS TO FURTHER AIDS PREVENTION IN THE WORKPLACE

The "willingness of the companies to further AIDS prevention in the workplace" requires the respondents to express a personal opinion.

The findings in Table 7 (see appendix P for complete crosstabulation) show that the majority of the respondents from companies which have a **formal/informal AIDS policy** and those which have **none at all**, believe that their companies are willing to devote additional resources (eg: finance/time) to preventative AIDS provisions (policy and education) in the workplace.

Conclusion

(A)

$H_{o(1)}$: **The majority of companies do not have a FORMAL AIDS policy.**

The findings as presented above **support** this hypothesis.

The findings indicate **that only 32% of the companies have formal AIDS policies**, 19% have informal AIDS policies.

The following section continues the investigation into the actions which the companies have taken with respect to AIDS, and deals with the central issue of **Preventative AIDS Education.**

6.4 Findings: Preventative AIDS Education

(see appendix A: Questions 24-33)

The purpose of this section is to:

- Establish the **type** of **management** and **employee** AIDS education
- Investigate whether the **number of employees** influences the **volume** of AIDS education
- Discuss the companies with **organised preventative AIDS education**
- Analyse the **differences** between **management** and **employee** AIDS education.
- Highlight the reasons for **not** undertaking **preventative AIDS education.**

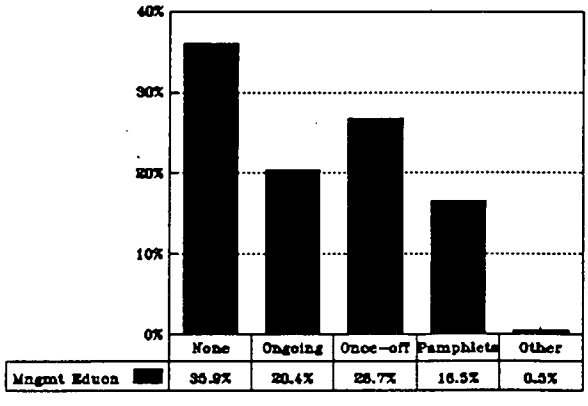
The issues covered in this section deal both with areas where the respondents can be considered qualified to speak on behalf of the companies, and areas where personal opinion is needed in order to elicit a response. The latter responses will be highlighted.

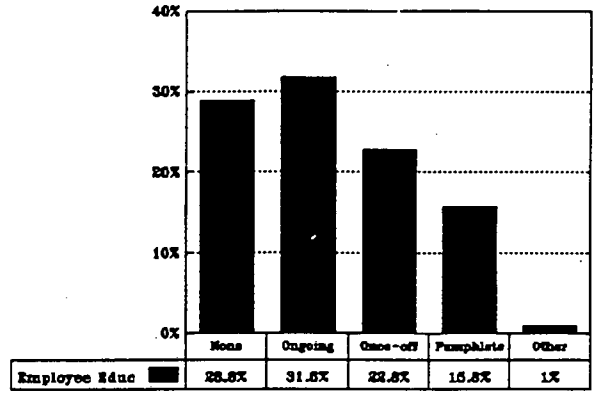
The secondary/informal research found that "only posters/pamphlets" cannot be classified as organised preventative AIDS education. The "organised" education therefore refers to ongoing and once-off AIDS education programmes only.

The informal research revealed that different companies have different kinds and combinations of AIDS education. The options "ongoing **workshops**" and "once-only **workshops**" in Question 24 refer to these generic forms of AIDS education - an AIDS education programme which consists of different combinations of tools and techniques. For example: posters/pamphlets, visiting speakers, videos, guidance/ counselling, etc.

(i) Type of Preventative AIDS Education

(see appendix A: Question 24a,24b)





n=284

FIGURE 11(a)

n=284

FIGURE 11(b)

FIGURE 11(a): MANAGEMENT AIDS EDUCATION

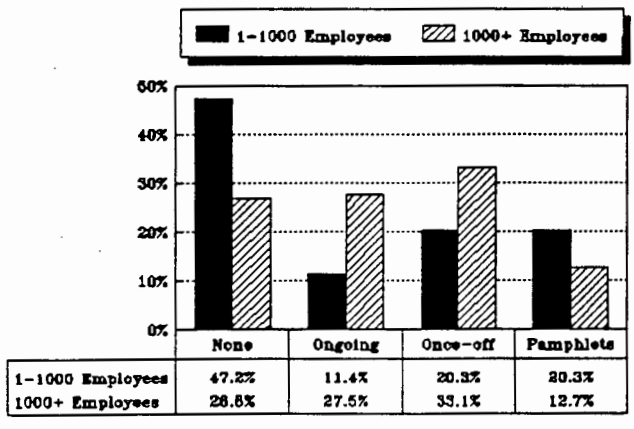
FIGURE 11(b): EMPLOYEE AIDS EDUCATION

The findings in Figure 11(a) and Figure 11(b) indicate that **47.1% of the companies have organised education for management** (**20.4% ongoing**, 26.7% once-off), while **54.4% have organised education for employees** (**31.6% ongoing**, 22.8% once-off). This is in accordance with the view that: 'Business must recognise that there's no preventive medicine and no cure for this disease. Education is the vaccine.' (Sher: 1989)

More respondents answered "**none**" to the type of **management** AIDS education (35.9%), than to the type of employee education (28.8%).

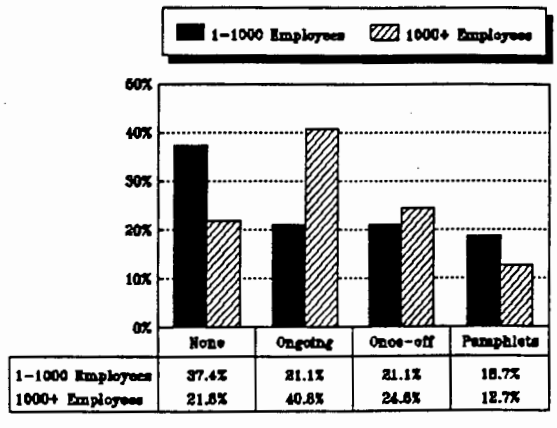
Approximately 16% of the companies have "**only posters/ pamphlets**" for management and employees.

(ii) Number of Employees and Volume of AIDS Education



n=265

FIGURE 12(a)



n=265

FIGURE 12(b)

FIGURE 12(a): NUMBER OF EMPLOYEES AND MANAGEMENT AIDS EDUCATION

FIGURE 12(b): NUMBER OF EMPLOYEES AND EMPLOYEE AIDS EDUCATION

Figures 12(a) (see appendices Q_1 and Q_2 for complete crosstabulation) and 12(b) (see appendix R_1 and R_2 for

complete crosstabulation) indicate the results of a crosstabulation conducted on Question 24 (The type of management and employee AIDS education), and Question 3 (The size of the company):

Figure 12(a) indicates that the companies with **more than 1000** employees have **more organised management AIDS education** than the companies with less than 1000 employees. (27.5% as opposed to 11.4% ongoing education, 33.1% as opposed to 20.3% once-off education.)

Figure 12(b) shows that the companies with **more than 1000** employees have **more organised employee AIDS education** than the companies with less than 1000 employees. (40.8% as opposed to 21.1% ongoing education, 24.6% as opposed to 21.1% once-off education.)

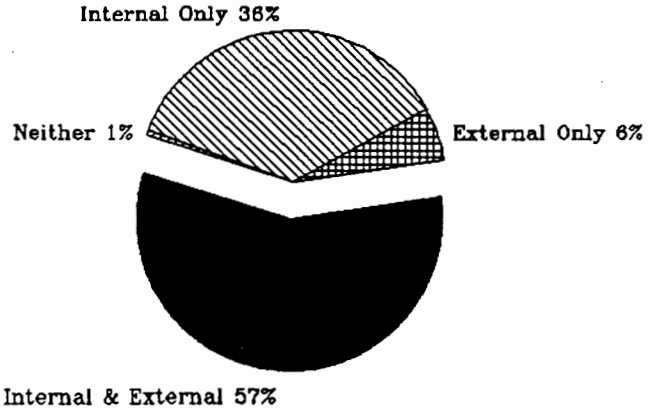
(iii) With respect to the companies with Organised Preventative AIDS Education:

This section deals with the following areas:

1. Staff Involved in the Organised AIDS Education
2. How Staff Qualify to become AIDS Educators
3. Factors which Shape the Organised AIDS Education
4. External Organisations Involved in the AIDS Education

1. Staff Involved in the Organised AIDS Education

(see appendix A: Question 25)



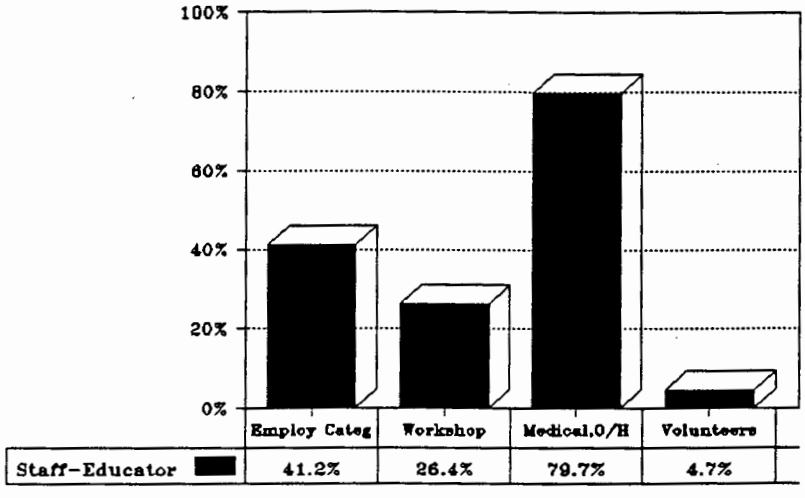
n=157

FIGURE 13: STAFF INVOLVED IN THE ORGANISED AIDS EDUCATION

Figure 13 shows that 57% the companies have **both internal staff and external organisations** dealing with the AIDS education, and to a lesser extent only internal staff (36%). An absolute minority only involve external organisations (6%).

2. How Staff Qualify to become AIDS Educators

(see appendix A: Question 26)



n=148

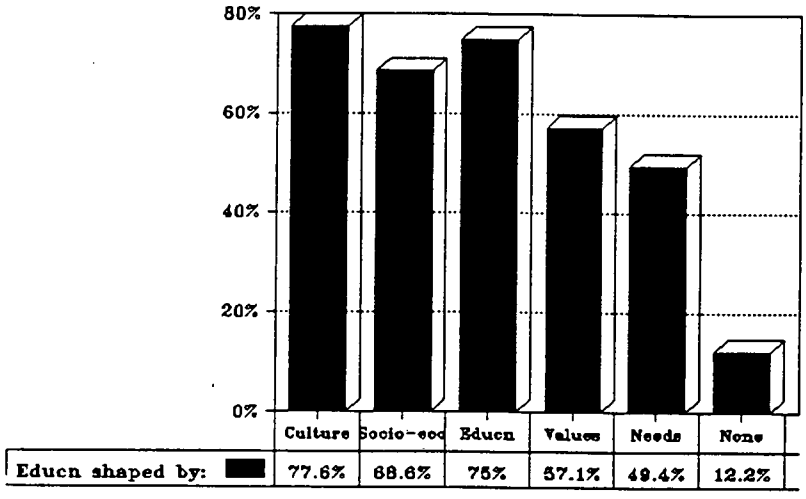
FIGURE 14: HOW STAFF QUALIFY TO BECOME AIDS EDUCATORS

Figure 14 indicates that the majority of the respondents stated that staff qualified to become AIDS educators primarily by being a **medical/occupational health person** (79.7%), secondly by **virtue of employment category** (41.2), and thirdly by attending workshops/conferences (26.4%). A minority of staff qualify to become AIDS educators by volunteering. (4.7%)

3. Factors which Shape the Organised AIDS Education

(see appendix A: Question 32)

The respondents are required to express a personal opinion on what factors shape the preventative AIDS education.



n=157

FIGURE 15: FACTORS WHICH SHAPE THE ORGANISED AIDS EDUCATION

Figure 15 shows that the respondents believe that most of the organised education is shaped by different **cultures** (77.6%), **education** levels (75%), **socio-economic** backgrounds (68.69%), and to a lesser extent different values (57.1%), needs and emotions (49.4%). Only 12.2% of the respondents believe that their AIDS education is not shaped by any of the above factors.

A crosstabulation was conducted on Question 32 (Factors which shape the AIDS education), and Question 24 (The type of AIDS education). The findings show that the respondents believe that culture, education and socio-economic backgrounds, as well as values, needs and emotions of the audience, play a larger part in shaping the **ongoing** AIDS education for management and employees than the once-off education. (see appendix S)

4. External Organisations Involved in the AIDS Education

(see appendix A: Question 27)
(see appendix C: List of AIDS Organisations in Cape Town)

Question 27 aims to establish which external organisations were involved in the companies' organised AIDS education:

The "Department of National Health and Population Development" received the strongest response to Question 27 (42.42%). The "Johannesburg AIDS Information Centre" received the second strongest response (18.18%), followed by the "Institute of Personnel Management" (15.15%). (n=99)

To a lesser extent, the following external organisations were involved in the AIDS education programmes: "AIDS Training and Information Centres" (9.09%), The "Chamber of Mines" (8.08%), "Planned Parenthood Association" (4.04%), The "Gay Association of South Africa" (2.02%), and "Johannesburg General Hospital" (1.01%). (n=99)

(iv) An Analysis of Dissimilarities regarding the Management and Employee Preventative AIDS Education Programmes:

This section deals with the following area:

1. Management and Employee Education in the **Same Company**
2. The **Form** of Management and Employee AIDS Education
3. **Union** Involvement in Management and Employee AIDS Education
4. The **Effect** which AIDS Education is Expected to have on Management and Employees
5. Management and Employee AIDS Education and Their Levels of AIDS **Awareness**

The following findings emerge:

1. **Management and Employee Education in the Same Company**

	MANAGEMENT EDUCATION	
	Ongoing	**Once-off**
ONGOING EMPLOYEE EDUCATION	61.1%	24.4%

n=90

TABLE 8: MANAGEMENT AND EMPLOYEE AIDS EDUCATION IN THE SAME COMPANY

Table 8 is derived from the complete crosstabulation table of the two parts of question 24 shown in appendix T.) Table 8 shows that in the same company, **management and employee education are not necessarily the same:** For example: 24.4% of the companies which have ongoing AIDS education for employees, only have once-off education for management. (61.1% do have ongoing education for both management and employees.)

2. **The Form of Management and Employee AIDS Education**

(see appendix A: Questions 28 and 29)

(multiple responses permitted)

	Management	**Employees**
Posters/ Pamphlets	59.0%	**81.2%**
Meetings	**45.5%**	38.3%
Videos	76.1%	**86.4%**
Visiting "Experts"	**43.3%**	35.7%
Workshops	45.5%	47.4%
Conferences	**27.6%**	10.4%
Counselling	35.8%	**59.1%**
	n=134	n=154

TABLE 9: THE FORM OF THE MANAGEMENT AND EMPLOYEE AIDS EDUCATION

The option "workshops" in Questions 28 and 29 is a potential area of confusion. The results must therefore be interpreted with care. The aim of Question 28 and 29 was to expand on the "generic concept" of AIDS education (Question 24), and establish the specific methods utilised in the AIDS education programmes. The option "workshops" was included in order to ensure that the list of options was exhaustive. "Workshops" therefore refers to a combination of AIDS education tools and techniques not adequately covered by the rest of the options listed in Questions 28 and 29.

From Table 9 it can be seen that more emphasis is placed on **videos**, **posters/pamphlets** and **guidance/ counselling** in the **employee** education, while **management** education includes more **meetings**, **visiting experts** and **conferences**.

The respondents were asked to **rank** the above forms of management and employee AIDS education in order of importance. The responses to the rankings were varied. "**Videos**" and "**Workshops**" received the most responses for the "first most important", and "Videos" received the most responses for "second most important", for management and employee education. This is in accordance with the American Red Cross AIDS Prevention Programme for the Workplace, where videos are recommended for introductory sessions to explain the facts, as well as for workshops. During the workshops, three minute video scenarios, depicting "real" AIDS-related Workplace issues are shown, followed by discussions. (American Red Cross AIDS Prevention Programme: 1990)

3. Union Involvement in Management and Employee AIDS Education

(see appendix A: Question 33)

> 'AIDS was turned into top union priority this weekend as COSATU held its first conference devoted to developing a policy in the epidemic.' (Sunday Times: 30/6/91)
>
> 'We (COSATU) can no longer afford to neglect the problem of AIDS... The epidemic is a union issue. We have a responsibility to confront it, **educate workers** and to establish fair AIDS policies in the workplace.' (Lehoko: 1990)

Table 10 is derived from the complete crosstabulation table of questions 24 and 33 shown in appendices U_1 and U_2.

Appendix: U_1 U_2

	MANAGEMENT EDUCATION		EMPLOYEE EDUCATION	
	ONGOING	ONCE-OFF	ONGOING	ONCE-OFF
UNION INVOLVEMENT	**51.7%**	**37.3%**	**47.2%**	**30.2%**
	n=134		n=155	

TABLE 10: UNION INVOLVEMENT IN ORGANISED AIDS EDUCATION

Table 10 shows that there is **more union involvement in the organised management AIDS education** (51.7% ongoing; 37.3% once-off), than in the organised employee education (47.2% ongoing; 30.2% once-off).

4. The Effect Which the AIDS Education Is Expected to have on Management and Employees

(see appendix A: Questions 30 and 31)

Questions 30 and 31 required a response based on the knowledge and personal opinion of the respondent.

Most of the respondents are confident that their preventative AIDS education programmes will have a **positive effect** on **management** and **to a slightly lesser degree on employees** too.

The majority of the respondents expect the **management education** to lead to **"a greater awareness of the potential impact of AIDS in the workplace"** (82%), and **"a medical/factual understanding"** (68%). To a lesser extent, it is believed that it will lead to "more acceptance/tolerance of HIV-positive people" (43%), and "less promiscuity" (13%). (n=134)

The majority of the respondents expect the **employee education** to lead to **"a greater awareness of safer sex"** (75%). To a lesser extent, it is believed that it will lead to "a medical/factual understanding" (59%), "more acceptance/tolerance of HIV-positive people" (38%), and "less promiscuity" (21%). (n=153)

5. Management and Employee AIDS Education and Their Levels of AIDS Awareness

(see appendix A: Questions 23 and 24)

Table 11 is derived from the complete crosstabulation table of questions 23 and 24 shown in appendices V_1 ("management awareness and AIDS education") and V_2 ("employee awareness and AIDS education").

	Unaware	Low	Moderate	High
"Ongoing" Management	0	3.4%	**41.4%**	**55.2%**
"Ongoing" Employees	3.3%	25.6%*	53.3%*	14.4%
"Once-off" Management	0	3.9%	**53.9%**	**42.1%**
"Once-off" Employees	1.5%	38.5%*	44.6%*	12.3%

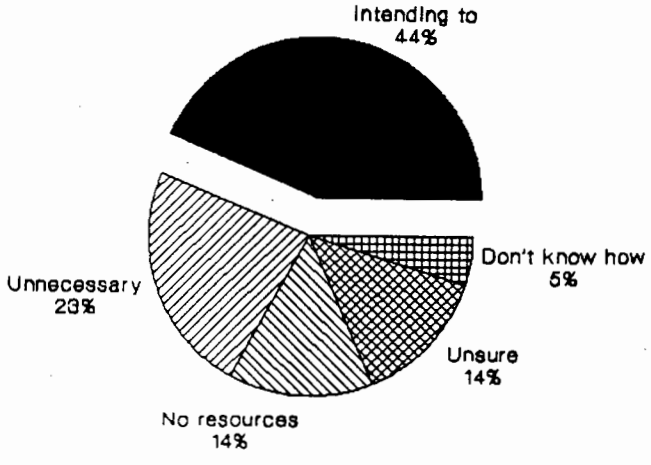
n=284

TABLE 11: MANAGEMENT AND EMPLOYEE AIDS EDUCATION AND THEIR LEVELS OF AIDS AWARENESS

The responses to this question of management and employee levels of AIDS awareness are based on the knowledge and personal opinions of the respondents.

The bold and underlined percentages in Table 11 highlight that an overwhelming majority of the respondents from companies which have **ongoing/once-off education for management**, consider **management** to have a **moderate to high** awareness of AIDS. The percentages which are marked with an asterisk indicate that the majority of the respondents from companies with **ongoing/once-off employee AIDS education**, consider **employees** to have a **low to moderate** awareness of AIDS.

(v) With respect to the companies with no organised preventative AIDS education for management or employees: (see appendix A: Question 24c)



n=124

FIGURE 16: REASONS FOR NOT UNDERTAKING AIDS EDUCATION

The responses to this question: "reasons for not undertaking AIDS education", are based on the knowledge and personal opinions of the respondents.

From Figure 16 the reasons given by the respondents for the companies not undertaking preventative AIDS

education can be seen: **"Intending to do so shortly"** received the strongest response (44%). 23% consider preventative AIDS education **"unnecessary"**. The remaining respondents stated that they **"have inadequate resources"** (14%), were **"unsure"** why they have no AIDS education (14%), and to a lesser extent "did not know how to go about it" (5%).

(The options in Question 24c are mutually exclusive. The "unsure" response reflects the respondents' doubt.)

Conclusion

(A)
Ho(2): The majority of the companies do not have ONGOING AIDS education for management and employees

The findings **as presented above support** this hypothesis.

Only 20% of the companies have ongoing preventative AIDS education for management, and 32% have ongoing education for employees.

The following section deals with the research findings on the Recruitmemt and Selection Policies of the companies with respect to AIDS.

6.5 Findings: Recruitment and Selection Policies:

The purpose of this section is to establish:

- The recruitment and selection procedures for applicants with **life-threatening** diseases, and applicants with the **HIV virus.**

- What **medical** checks exist for applicants at recruitment and selection

- The extent of and methods of **HIV pre-employment testing**

The issues covered in this section deal both with areas where the respondents are qualified to speak on behalf of the companies - as a result of their expertise and knowledge, and areas where personal opinion is needed in order to elicit a response. The latter will be highlighted.

(i) Recruitment and Selection Procedures for Applicants with Life-threatening Diseases, and Applicants with the HIV Virus.

The recruitment and selection procedures with respect to applicants with HIV and those with general life-threatening diseases, may require the respondents to express a personal opinion - especially where the company concerned has no formal policy regarding this issue.

Questions 7 and 8 were designed in order to establish:

- What recruitment/selection policies the companies have for suitable applicants with the **HIV virus** and those with **general life-threatening diseases**
- Whether the respondents from companies **differentiate** between suitable HIV-positive applicants and suitable applicants with other life-threatening diseases in their recruitment and selection procedures. (The questionnaire states that it is assumed that the respondents know whether the suitable applicant has a general life-threatening disease or whether he/she is HIV positive.)

	Applicant: life-threatening disease	Applicant: HIV virus
No policy, usually turn away	22.9%	**27.8%**
No policy, depends on circumstances	**37.0%**	28.9%
No policy, does not matter	1.4%	0%
Policy to employ, no provisos	4.2%	4.2%
Policy to employ, with provisos	**11.6%**	6.3%
Policy not to employ	18.3%	17.3%
Unsure	4.6%	**15.5%**
	100%	100%

n=284

TABLE 12: RECRUITMENT POLICIES FOR SUITABLE APPLICANTS WITH HIV AND WITH GENERAL LIFE-THREATENING DISEASES

(The "unsure" category above reflects the respondents' doubt with respect to Questions 7 & 8. Both questions are mutually exclusive questions.)

Table 12 shows **the recruitment and selection policies as stated by the respondents from the companies for suitable applicants with life-threatening diseases and the HIV virus:** (Being infected with the HIV does not in itself affect an individual's ability to perform the duties associated with most jobs: 'HIV-positive job applicants may have years of constructive healthy service ahead of them. To exclude them from employment lacks a rational foundation and is unfair.' (Cameron: 1991)

Table 12 indicates the following: None of the respondents from companies with **no AIDS policies** stated that it would not matter if they employed an applicant with HIV. A minority responded that they **have a policy** to employ such an applicant with no provisos (4.2%), or with provisos (6.3%). 17% of the respondents have a policy not to employ applicants with HIV.

More respondents stated "**no policy, would usually turn away**" (27.8%), and "**unsure**" (15.5%) for **HIV-positive applicants**, while more respondents answered "**no policy, depends on circumstances**" (37.0%), and "**policy to employ with certain provisos**" (11.6%) for applicants with **general life-threatening** diseases.

A **crosstabulation** on Questions 7 and 8 reveals that, although slight, some of these respondents do **differentiate** between terminally ill applicants and those with the HIV virus. This is in conflict with the view (Knobel: 1989), that applicants with general life-threatening diseases and those who are HIV-positive should be treated the same. Where the procedures do differ, it is the HIV-positive applicants which usually receive the less favourable treatment. For example:

Tables 13(a) and 13(b) are derived from crosstabulations conducted on Question 7 and 8. The complete tables are shown in appendices Y_1 and Y_2 respectively.

	HIV+ APPLICANT		
	"No policy, turn away"	**"No policy, depends"**	**"Policy not employ"**
TERMINAL APPLICANT **"No policy depends"**	19.0%	56.2%	4.8%

n=284

TABLE 13(a): RECRUITMENT POLICY: HIV AND TERMINAL APPLICANTS

Table 13(a) shows that: 56.2% of the respondents from companies which have "**no policy, depends on circumstances**" for applicants with **terminal diseases**, stated they have this policy for HIV-positive applicants too. **However**, 19% which have this policy for terminal diseases, would usually turn away an HIV-positive applicant, and 4.8% have a policy not to employ HIV-positive applicants.

	APPLICANTS WITH LIFE-THREATENING DISEASES		
	"No policy depends"	**"Employ provis**	**"Policy not to employ**
HIV+ **"Policy not to employ"**	10.2%	6.1%	67.3%

n=284

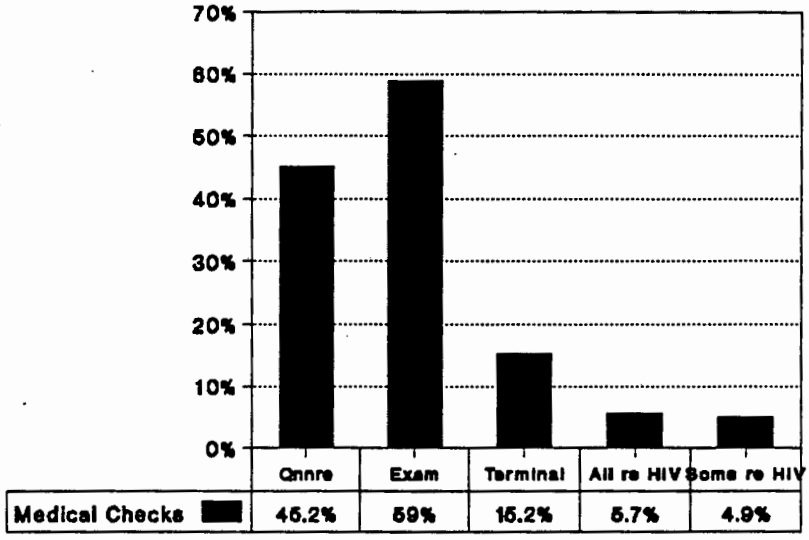
TABLE 13(b): RECRUITMENT POLICY: HIV AND TERMINAL APPLICANTS

Table 13(b) shows that: 67.3% of the respondents from the companies which have a "**policy not to employ HIV-positive applicants**", stated they have this policy for applicants with terminal disease too.

However, a further 16.3%, have this policy for **HIV-positive applicants only**, while the applicants without the HIV virus, will be judged on circumstances or employed with provisos.

(ii) Recruitment and Selection Procedures: Medical Checks

(see appendix A: Question 4)



n=283

FIGURE 17: TYPES OF PRE-EMPLOYMENT SCREENING

Figure 17 shows the companies which have medical questionnaires, medical examinations, screening of all applicants for life-threatening diseases and the HIV-virus, as well as those companies which only have HIV testing for certain applicants. Note should be taken of the following WHO statement: 'Pre-employment HIV/AIDS screening as part of the assessment of fitness to work is unnecessary and should not be requested.' (WHO: 1988)

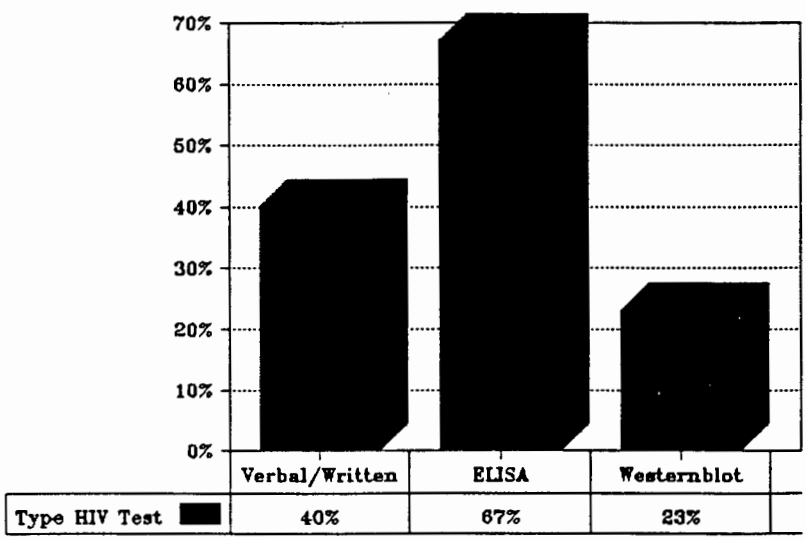
An interest in the medical fitness of applicants is exhibited by the companies which have medical questionnaires (45.2%) and medical examinations (59%). Only 15% of the companies test applicants for terminal illnesses. A **minority** (5.7%) test **all** applicants for the **HIV virus. A few** of the companies **(4.9%) have HIV testing for certain applicants** at recruitment.

(iii) The Extent of and Methods of HIV Pre-Employment Screening

(see appendix A: Question 5)

Despite a minority of the companies undertaking HIV pre-employment screening, the "type of testing" and a brief "profile" of these companies shall be discussed. This is owing to the highly contentious and topical nature of the issue, as well as the need for insight into companies which have taken this highly controversial step:

From an analysis of the companies which do have some form of HIV testing: (6% have testing for everyone, 5% for certain applicants (n=283), **the following emerges:**



n=30

FIGURE 18: TYPES OF HIV TESTING METHODS USED

Figure 18 shows that the testing mostly involves the **ELISA Test** (67%), as well as **Verbal/Written** questions (40%), and the **Westernblot Test** (23%). A crosstabulation of this question - Question 5 reveals that: (see appendices Z_1 to Z_3 for the complete crosstabulation tables) 42% of the companies have Verbal/Written screening and the ELISA Test, and 25% have Verbal/Written and the Westernblot Test. Only 5% have both the ELISA and Westernblot Tests. This is in conflict with: '(The ELISA Test)... has a high false positive rate and must therefore be confirmed by a more complex test called the Westernblot before a patient is informed.' (GASA: 1988) Almost all these tests (90%), are compulsory. This is in contrast with the widely held belief that mandatory testing of job applicants should not be undertaken.

The following table presents a "profile" of the companies with compulsory HIV testing, with respect to preventative AIDS provisions.

Company size	
1-1000 Employees	37.5%
1000+ Employees	62.5%
Terminal Applicant Policy not Employ	50.0%
HIV+ Applicant Policy not Employ	61.5%
AIDS will decrease **productivity** of co	88.5%
AIDS will be very **costly** to co	73.1%
Impact AIDS on co	
in 5yrs:"some"	38.5%
" a lot"	46.2%
Formal Policy	76.9%
Informal Policy	23.1%
Organised **Education Management**	83.7%
Organised **Education Employees**	88.5%

n=26

TABLE 14: A BRIEF "PROFILE" OF THE COMPANIES WHICH HAVE COMPULSORY SELECTIVE HIV TESTING:

Table 14 has been derived from crosstabulations conducted on question 6 ("Compulsory HIV testing") and questions 3,7,8,14,15,17,24. The complete, individual crosstabulation tables are shown in appendices AA to HH.) The following findings emerge:

From Table 14 it can be seen that it is mostly the companies with **more than 1000** employees which have selective compulsory HIV testing at the recruitment and selection stage. (see appendix AA) **More** respondents from companies stated that they **have a policy to turn a HIV-positive applicant away** than an applicant with any other life-threatening disease. (see appendix BB and CC) An overwhelming majority of the respondents believe that the **impact** of AIDS on their companies will be "**some**" or "**a lot**" in 5 years time. (see appendix FF) More specifically, this is expected to be in the form of decreased productivity (appendix DD) and to a slightly lesser extent, very high costs (appendix EE). All these companies have AIDS policies, mostly formal (appendix GG), and the vast majority have organised **education for management and employees.** (appendix HH)

The findings on recruitment and selection policies: Whether the respondents from the companies differentiate between applicants with general life-threatening diseases and those with HIV, as well as the medical checks which exist for applicants, extent and methods of testing, have been analysed.

Conclusion

(B)
Ho(1) **AIDS has had no influence on recruitment and selection policies**

The findings **as presented above do not support** this hypothesis. Although AIDS has not influenced recruitment and selection procedures to the extent of the majority of the companies undertaking pre-employment screening, **the findings above show that there most certainly is an impact.**

6.6 Findings: AIDS and Current Employees

The purpose of this section is to establish:

- Whether the companies **offer HIV testing** to their employees
- Whether the **confidentiality** of an employee with the HIV virus is maintained
- What **action** the companies would take with an HIV-positive employee
- Whether AIDS has affected the **group benefit schemes**

The respondents are qualified to represent the companies concerned regarding the issues above, as these areas are either policy-related or company practice and are therefore of a factual nature.

- **HIV Testing For Current Employees**

(see appendix A: Question 9)

> 'Individual testing ... is difficult if not impossible to justify in the employment context. The question is whether an employer could possibly have a rational and fair reason for wanting to know whether an otherwise healthy and productive employee is HIV-positive. For this reason the health ministers of the European Community concluded that screening and mandatory testing of existing employees to determine HIV status were "inappropriate". Even if the employee is sick but accepts the usual consequences of inability to perform under the contract of employment, it is doubtful whether the employer has a warrantable claim to know whether the disability is AIDS-related.' (Cameron: 1991)

26% of the companies offer **HIV testing** to employees (in the workplace/refer to external bodies), mostly **on request.** (n=283) This is in accordance with the belief that an employer should not unilaterally introduce compulsory routine HIV-testing into the company as this could expose him to unfair labour practice accusations. (Strauss: 1988) A minority have compulsory HIV testing for current employees (5%).

- **Confidentiality**

(see appendix A: question 13)

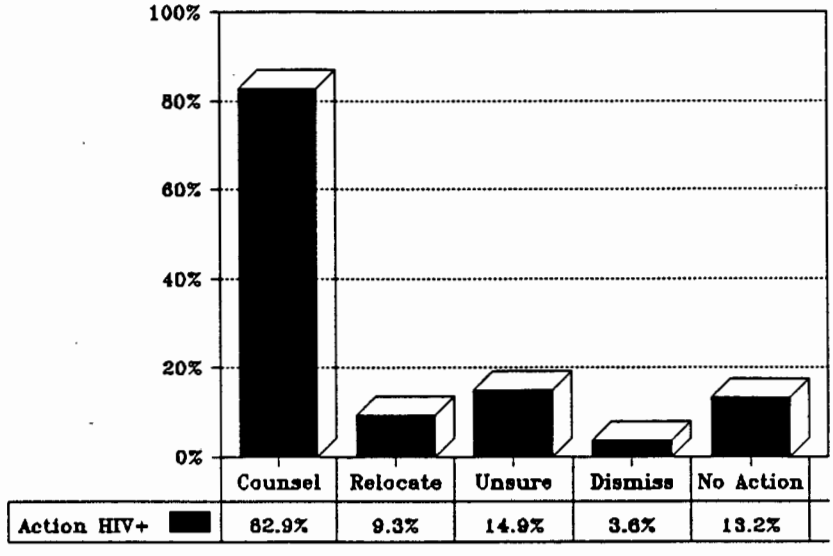
> 'The disease and infection with the virus that leads to it must not be treated differently in the workplace from any other issue, except in one respect: that AIDS sufferers and HIV carriers are more vulnerable to stigmatisation and ostracisation by fellow employees (and other people) than employees afflicted by other medical conditions. The result is that an employer who comes to know of an employee's condition regarding AIDS or HIV bears a heavy burden of confidentiality in relation to this information.' (Cameron: 1991)

An overwhelming majority of the respondents (89%), stated that if an employee were HIV-positive, it would be kept confidential (n=281). This conforms to the WHO statement on confidentiality: 'Confidentiality regarding all medical information including HIV/AIDS status, must be maintained.' (WHO: 1988)

(The options in Question 13 are mutually exclusive. The "unsure" category reflects the respondents' doubt. 7.83% responded unsure.)

- **Action Regarding an HIV-positive Employee:**

(see appendix A: Question 12)



n=281

FIGURE 19: ACTION REGARDING HIV-POSITIVE EMPLOYEE

Figure 19 shows that the majority of the companies (82.9%) would refer an HIV-positive employee to **guidance/counselling**. (This is widely supported, for example, Knobel: 1989, GASA). To a far lesser extent the respondents are **unsure** what to do (14.9%), **would take no action** (13.2%), **relocate** (9.3%) or **dismiss** (3.6%). (The aforementioned responses are often in conjunction with "refer to guidance/counselling".)

(Question 12 is of a multiple response nature. 14.9% responded "unsure". This reflects personal doubt. Since some of the respondents ticked both "unsure" and "guidance/counselling", the results should be interpreted with care.)

- **AIDS and Group Benefit Schemes**

  (see appendix A: Question 17.1)

Most companies have **not made special provision for AIDS in their group benefit schemes** (71%: formal policy; 76%: informal policy). (The WHO states that 'HIV-infected employees should not be discriminated against...(with respect to) occupationally related benefits'.) (WHO: 1988)

Conclusion

(B)
Ho(2) **An HIV-positive employee will not be permitted to continue working as before.**

The findings **as presented above do not support** this hypothesis.

The findings show that the majority of the companies will permit an HIV-positive employee to continue working as before.

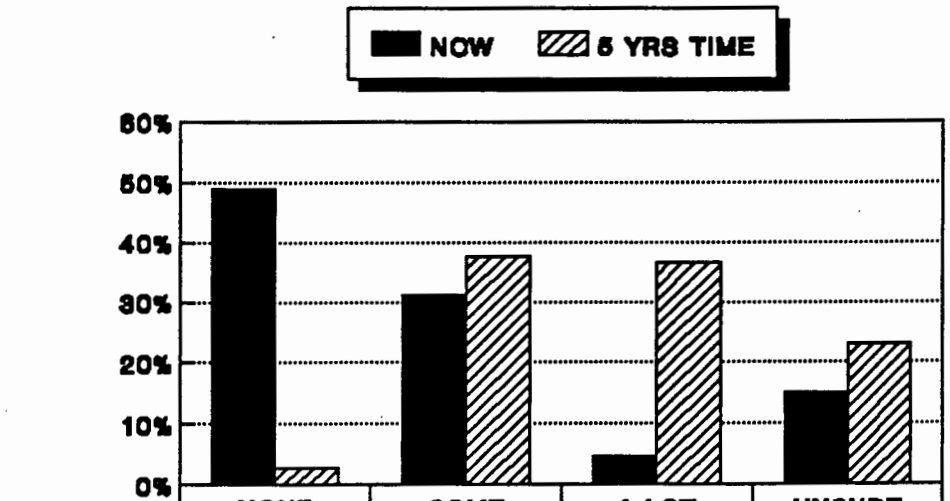
6.7 Findings: The Effect of AIDS on the Company

The purpose of this section is to examine the **expected impact of AIDS on the companies** from **three perspectives:** (From the broad to the specific.)

- The **Overall Impact** that AIDS is expected to have on the companies
- The **Manner** in which AIDS is expected to affect the companies
- The expected effect an **HIV-positive employee** will have on the **department** in which he/she works

In this section of the questionnaire, the respondent is required to express a **personal opinion** on the effect of AIDS on the company.

(i) The Overall Impact that AIDS is expected to have on the companies:



	NONE	SOME	A LOT	UNSURE
NOW	48.9%	31.2%	4.6%	15.2%
5 YRS TIME	2.8%	37.6%	36.5%	23%

n=282

FIGURE 20: THE EXPECTED IMPACT OF AIDS ON THE COMPANIES

Figure 20 shows the different expectations of the impact of AIDS on the companies **now** and in **five years** time. (see appendix A: Question 15)

(The options in Question 15 are mutually exclusive. The "unsure" response reflects the respondents' doubt. 15.25% responded "unsure" to the current impact of AIDS, while 23.05% responded "unsure" to the impact of AIDS in 5 years time.)

While 48.9% of the respondents perceive AIDS to have **no impact** on their companies **now, only 2.8%** expect this to be the case **in five years** time. Additionally, whereas only 4.6% perceive the impact to be "a lot" on their company now, **36.5%** expect the impact to be **"a lot" in five years time.** This is in accordance with the statistics on the effect of AIDS, worldwide and in South Africa. According to Dr Malcolm Steinberg of the South African Medical Research Council, (July 1991), if behaviour does not change, more than 5 million South Africans will be infected with HIV by the year 2000, and more than 500 000 would have died. The AIDS virus will peak in 2005: more than 7 million could be infected, and cumulative AIDS deaths are predicted to be in the region of 2.9 million.

> 'The worldwide AIDS epidemic is one of the deadliest diseases threatening mankind today. At this stage, there is no evidence that the bleak scenario regarding the spread of the virus in South Africa will not become a reality. Failure to deal effectively with AIDS right now will severely threaten the whole business environment...' (Van Niekerk: 1991)

IMPACT OF AIDS IN **FIVE** YEARS TIME					
IMPACT **NOW**	NONE	SOME	A LOT	UNSURE	TOTAL
NONE	5.1%	**53.6%**	17.4%	23.9%	48.9%
SOME	1.1%	17.0%	**72.7%**	9.1%	31.2%
A LOT	0	23.1%	76.9%	0	4.6%
UNSURE	0	32.6%	11.6%	55.8%	15.2%

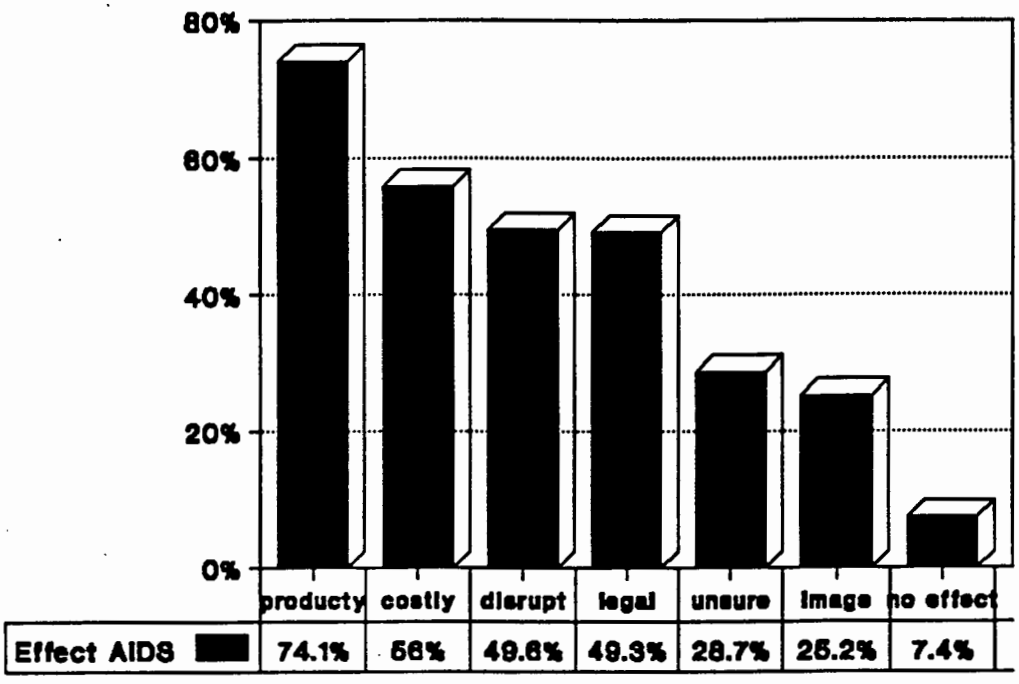
n=282

TABLE 15: CHANGE IN THE COMPANIES' EXPECTATION OF THE IMPACT OF AIDS NOW AND IN FIVE YEARS TIME

Table 15, (see appendix II for the complete crosstabulation), derived from a crosstabulation which was conducted on the two parts of **Question 15** (the expected impact of AIDS now and in five years time), illustrates the **change in the respondents' expectations of the impact of AIDS now and in five years time.**

A minority of the respondents who responded "none" to the current impact of AIDS, expect this to be the impact in five years time (5.1%). Furthermore the majority who perceive "some" impact now, expect the impact of AIDS on their company to be "a lot" in five years time (72.7%). (The respondents who expect AIDS to lead to decreased productivity and high costs, predict the impact in five years time to be "some" and "a lot.

(ii) The Manner in which AIDS is Expected to Affect the Companies
(see appendix A: Question 14)



n=282

FIGURE 21: THE MANNER IN WHICH AIDS IS EXPECTED TO INFLUENCE THE COMPANIES

Figure 21 shows that **only 7.4%** of the respondents **do not expect AIDS to affect their companies. "Decreased productivity"** (74.1%) (eg: increased absenteeism/ shortage of skilled manpower) firstly, and **"very costly"** (56%) secondly, are considered to be the most likely effects. (This is supported by Sanlam:, 1988). Approximately half the respondents expect AIDS to **disrupt the conduct of business**, have **legal implications** and, to a lesser extent, be detrimental to their company image. Many of the respondents believe that AIDS will affect them in more than one of the above ways. For example, more than 50% of the respondents expect "decreased productivity" to be accompanied by "very costly", "disruption of the conduct of business" and "legal implications".

(Question 14 is of a multiple response nature. 28.7% ticked "unsure". The "unsure" response reflects the respondents' personal doubt. Since some of the respondents ticked both "unsure" and another option, there exists an element of uncertainty and the results should therefore be interpreted with care.)

(iii) With respect to the expected effect which an HIV-positive employee would have on the department in which he/she works:

Question 16 (see appendix A) was designed in order to establish whether **co-workers "knowing" or "not knowing" would make any difference to the department in which an HIV-positive employee worked:** (n=283)

- **85%** of the respondents feel that **"co-workers knowing"** will be **harmful** to relationships between employees (eg: fear, rejection).
- **30%** responded that **"co-workers knowing"** will lead to **decreased performance of co-workers.**

However, irrespective of whether anyone knew or not, the majority responded that the **efficiency of the HIV-positive employee may decrease**, and an HIV-positive employee may be **hazardous due to possible injury.**

Medical evidence shows that the employee's job performance should not be affected until the later stages of the disease: 'HIV infection by itself is not associated with any limitation in fitness to work... As with many other illnesses, persons with HIV-related illness should be able to work as long as medically fit for available , appropriate work.' (WHO: 1988)

Many more respondents perceived "**no effect**" where **co-workers did not know** about the presence of an HIV-positive employee.

Conclusion

(B)
Ho(3) **AIDS is not expected to have an impact on the companies.**

The findings **as presented above do not support** this hypothesis.

The following section deals with the research findings on "The Levels of Management and Employee AIDS Awareness".

6.8 Findings: The Levels of Management and Employee AIDS Awareness

The purpose of this section is to examine the levels of **management** and **employee AIDS awareness** in the companies. (see appendix A: Questions 23a and 23b)

In this section of the questionnaire, the respondent is required to express a **personal opinion** on the levels of management and employee AIDS awareness.

	Unaware	Low	Moderate	High	Unsure
Management	1.8%	13%	47.9%	36.3%	1.1%
Employees	6.7%	38%	41.2%	10.8%	3.5%

n=284

FIGURE 22: LEVEL OF MANAGEMENT AND EMPLOYEE AIDS AWARENESS

Figure 22, illustrates that **management awareness** of AIDS is mostly considered by the respondents to be "**moderate to high**". (moderate: 47.9%; high: 36.3%)

Employee awareness of AIDS is mostly regarded as "**moderate to low.**" (moderate: 41.2%; low: 38%) An absolute minority of the respondents consider management and employees to be unaware of AIDS.

(The options in Questions 23a and 23b are mutually exclusive. The "unsure" response reflects the respondents' doubt. 1.06% responded "unsure" to management awareness of AIDS, while 3.52% responded "unsure" to employee awareness of AIDS.)

	EMPLOYEES				
	UNAWARE	LOW	MOD	HIGH	UNSURE
MNGMT					
UNAWARE	100.0%	0.0%	0.0%	0.0%	0.0%
LOW	29.7%	64.9%	2.7%	0.0%	2.7%
MOD	1.5%	47.1%	45.6%	2.2%	3.7%
HIGH	1.0%	19.4%	52.4%	26.2%	1.0%

n=284

TABLE 16: MANAGEMENT AND EMPLOYEE AIDS AWARENESS IN THE SAME COMPANIES

Table 16 has been drawn up from a from a crosstabulation (see appendix JJ for the complete crosstabulation), which was conducted on Question 23a and 23b ("management and employee AIDS awareness"). It indicates the respondents' opinions of **consistencies** and **discrepancies** of the awareness levels of management and employees in the same companies.

The following interesting findings emerge:

- 64.9% of the respondents who consider **management** to have a **low** awareness of AIDS, consider employees to have a low awareness too. However, a further 29.7% perceive **employees** to be **unaware.**

- 45.6% of the respondents who consider **management** to have a **moderate** awareness of AIDS, consider employees to have a moderate awareness too. However, 47.1% of these respondents perceive **employees** to have a **low** awareness.

- Only 26.2% of the respondents who perceive **management** to have a **high** awareness of AIDS, consider employees to have a high awareness too. 52.4% of the these respondents consider **employee** awareness to be **moderate.**

Conclusion

(B)
Ho(4) **Management and Employees do not have the same levels of AIDS awareness.**

The findings **as presented above support** this hypothesis

The strongest responses for both management and employees is "**moderate awareness**". Despite a similar percentage of respondents perceiving this, large **discrepancies** exist between the responses to "**low**" and "**high**" awareness for management and employees, particularly in the same companies. Where these inconsistencies do occur, management is almost always considered to be more aware.

6.9 Findings: Scope for Further AIDS Efforts

This section deals with the scope for both **internal** and **external** AIDS efforts of the companies. (see appendix A: Questions 34-40)

In this section of the questionnaire, the respondent is required to express a personal opinion on the scope for further AIDS efforts.

The following findings emerge:

- Almost all the respondents (87%) **are willing** to devote (additional) resources (eg: finance, time) to preventative AIDS provisions **in their workplace.** (n=275) (Question 34)

  'Instead of seeking only to minimise the impact HIV and AIDS will have on their particular enterprises, employers should join in the national effort to control the disease through information, education and compassionate treatment of those already affected by it.' (Cameron: 1991)

- **Only 44%** are prepared to provide assistance (with respect to preventative AIDS education in the workplace) to **less resourceful companies** (than themselves) (n=273). The most likely forms of assistance being shared expertise (98%), and to a far lesser extent financial aid (15%). (n=122) (Questions 35,36)

- **19%** of the companies assist in **community AIDS awareness/education campaigns**, (mainly in the form of supporting external organisations and to a lesser extent independent campaigns), (n=279). (Questions 37, 38)

- **28%** of the respondents from companies which do not currently assist community AIDS projects **would be willing** to do so in the next year (n=228). (Question 39)

Conclusion

(B)
Ho(5) **The respondents from the companies are not willing to devote (additional) resources to AIDS prevention internally.**

This findings as presented above show that the hypothesis is **not** supported by the findings.

Chapter 6 has investigated the preventative AIDS provisions which the companies in the sample are undertaking. The findings to the primary and secondary problems as stated in chapter 1 (1.3.1) have been analysed.

Chapter 7 which follows is concerned with the **Research Findings** and **Discussions** regarding the preventative AIDS provisions which the respondents consider **practical** to implement in their workplace.

CHAPTER SEVEN

RESEARCH FINDINGS AND DISCUSSION

7.1 Introduction

The aim of chapter 7 is to establish what AIDS-related workplace provisions the respondents consider **practical** to **implement in their workplace.**

Chapter 7 has been divided into three main parts:

7.2 AIDS Policy Approach

(a) General
(b) Pre-Employment AIDS Policy Issues
(c) "During Employment" AIDS Policy Issues

7.3 Workplace Preventative AIDS Education

(a) Educating About AIDS
(b) Features of a Workplace AIDS Education Programme

7.4 Overall Conclusion

The overall conclusion discusses the findings and discussions of chapter 7 in terms of the objectives, main and sub hypotheses as stated in chapter 1.

This section of the questionnaire (see appendix A) which relates to chapter 7, takes the form of various statements which the respondents were asked to rank according to the following scale:

1:	HIGHLY PRACTICAL
2:	PRACTICAL
3:	UNSURE
4:	IMPRACTICAL
5:	HIGHLY IMPRACTICAL

The tables which follow are according to this scale. For each "statement", the findings are **analysed and discussed.** (In the analysis, "practical" refers to the highly practical and practical responses; "impractical" refers to the highly impractical and impractical responses.)

The nature of the questions in this section required the respondents to express their personal opinions on the issues concerned. These views may or may not reflect the stance of the companies.

The following discussions are based on the results of the questionnaires and the interpretations of the author who has had extensive discussion with opinion leaders in all AIDS-related fields.

The findings, discussions and conclusions of the literature review, chapters 6 and 7 together form the basis of the recommendations which follow.

7.2 AIDS Policy Approach:

(a) General:

The purpose of Section 7.2(a) is to establish whether the respondents consider it practical within their company to: undertake preventative AIDS provisions before HIV-related issues arise; have a formal AIDS policy; and develop the policy by a multidisciplinary task force. (see Questionnaire: appendix A)

(i) The undertaking of preventative AIDS provisions (policy/education) before HIV-related issues arise in the workplace.				
1	2	3	4	5
39.71%	**48.38%**	7.22%	3.25%	1.44%
				=100%

n=277

TABLE 17: THE UNDERTAKING OF PREVENTATIVE AIDS PROVISIONS BEFORE HIV-RELATED ISSUES ARISE

Table 17 shows that 88.09% of the respondents consider it "**practical**" within their company to implement preventative AIDS provisions before HIV-related issues arise in their workplace. The World Health Organisation and International Labour Organisation (WHO & ILO) (appendix B) recommend that policies be developed and implemented before HIV-related questions arise in the workplace. (WHO & ILO: 1988) (see appendix B)

(ii) A formal, written AIDS policy.

1	2	3	4	5
40.87%	**40.14%**	12.41%	5.83%	0.75%
				=100%

n=274

TABLE 18: THE DEVELOPMENT OF A FORMAL AIDS POLICY

Table 18 indicates that 81.01% of the respondents stated that it is "**practical**" to implement a formal, written AIDS policy in their workplace. This is in accordance with WHO recommendations (WHO: 1988).

(iii) The development of an AIDS policy by a multi-disciplinary task force.

1	2	3	4	5
27.9%	**46.01%**	15.94%	7.25%	2.9%
				=100%

n=276

TABLE 19: THE DEVELOPMENT OF AN AIDS POLICY BY A MULTIDISCIPLINARY TASK FORCE

> 'Consistent policies and procedures should be developed through consultation between workers, employers and their organisations, and where appropriate, governmental agencies and other organisations.' (WHO & ILO: 1988)

Table 19 shows that 73.91% of the respondents consider it "**practical**" to involve representatives from different spheres of the organisation in the development of their AIDS policies.

Critical Members of an AIDS Task Force:

The aim of Question 48, was to gain more insight into the "**AIDS Task Force**", by establishing **which areas in a company** (in the opinion of the respondents) **are considered the most important and practical members.**

From this it can be deduced that a distinction exists between "important" members of the task force and "practical" members: Top management are considered more important while personnel/human resources are considered more practical.

Occupational/medical people received similar responses for "1st" importance (21.93%) and "1st" practicality (27.88%).

Table 21 is derived from the complete frequency tables shown in appendix LL. It shows the members of the task force which received the strongest responses for "2nd" most important and "2nd" most practical.

	2nd IMPORTANCE	2nd PRACTICALITY
Personnel/Human Resources	**41.13%**	36.88%
Union/Employee Representative	18.87%	**17.87%**
Occupational Health/ Medical People	17.36%	17.87%
	n=265	n=263

TABLE 21: MEMBERS OF THE TASK FORCE RANKED "SECOND MOST IMPORTANT" AND "SECOND MOST PRACTICAL"

Table 21 shows the members of the task force which received the strongest responses for "2nd" most important and "2nd" most practical.

Personnel/human resources received the strongest responses: 41.13% responded "important", 36.88% responded "practical". Therefore, a similar percentage of respondents believe that personnel/human resources are both important and practical members of an AIDS task force.

An interesting finding is that **unions/employee representatives** received strong responses in the second, third and fourth "important" rankings (2nd: 18.87%, 3rd: 21.09%, 4th: 33.04%) and "practical" (2nd: 17.87%, 3rd: 25.00%, 4th: 27.98%) rankings.

Overall, personnel/human resources, top management, unions/ employee representative and occupational health/medical people received the strongest responses in the "important" and "practical" rankings.

Summary:

Section 7.2(a) suggests that the majority of the respondents consider it practical to: undertake preventative AIDS provisions **before** HIV questions arise, have a **formal** AIDS policy, and develop the policy by a multidisciplinary **task force.** An assessment of this section is discussed in terms of the main and sub hypotheses in the overall conclusion to chapter 7. (7.4)

Section 7.2(b) which follows, deals with more **specific** AIDS policy issues: **Pre-employment Procedures.**

(b) Pre-Employment AIDS Policy Issues

The purpose of Section 7.2(b) is to establish whether the respondents consider the following pre-employment AIDS policy issues to be practical to implement in their workplace: (see Questionnaire: appendix A)

(i) HIV-antibody pre-employment screening
(ii) Employing an applicant with the HIV virus
(iii) Counselling applicants who are tested for HIV
(iv) Gaining consent before testing for HIV

(i) HIV-antibody pre-employment screening

> 'HIV pre-employment screening for everyone is a highly contentious issue: Pre-employment HIV/AIDS screening as part of the assessment of fitness to work is unnecessary and should not be required. Screening of this kind refers to direct methods (HIV testing) or indirect methods (assessment of risk behaviours), or to questions of HIV tests already taken. Pre-employment HIV/AIDS screening for insurance or other purposes raises serious concerns about discrimination and merits close and further scrutiny.' (WHO & ILO: 1988)

In South Africa, unlike the USA, employers may decide who they wish to employ. (Van Wyk: 1990) Employers may therefore request information on application forms which will inform them whether an applicant is HIV-positive, or they may also require prospective employees to undergo AIDS tests:

> '(Employers) may legally decide to exclude HIV-positive people from the workplace, although this does not seem ethical. If an applicant lies on his application form about his medical condition or supplies fraudulent details, such dishonesty may provide the employer with grounds to dismiss the employee... The employer to whom confidential information is imparted, will have to deal with it in a confidential manner or he may expose himself to a civil action for violation of the applicant's right to privacy.' (Van Wyk: 1990)

(i) HIV-antibody pre-employment screening for everyone.				
1	2	3	4	5
10.8%	22.0%	13.4%	**28.2%**	**25.6%**
				=100%

n=277

TABLE 22: HIV PRE-EMPLOYMENT SCREENING

From Table 22 it can be seen that the responses to this statement were varied:

53.8% of the respondents consider it "**impractical**" for their companies to undertake HIV pre-employment screening for everyone.

> 'Pre-employment testing can in fact lead to misconceptions and false confidence... Discriminatory testing encourages stigmatisation and ostracisation. It enhances "us" versus "them" perceptions: "AIDS is not my problem but theirs." This is dangerous. AIDS is everyone's problem... Isolating HIV positive job applicants and thereby stigmatising them will not diminish the scale of the national crisis.' (Cameron: 1991)

> 'Pre-employment testing cannot in any way guarantee a sanitised AIDS-free workforce. An applicant may test negative for HIV, get the job, and then turn seropositive (if the test was taken during the period before the antibodies show up on the test) or become infected with HIV after getting the job. Testing as a form of preventive insurance is therefore useless.' (Cameron: 1991)

> 'Testing is always a burdensome procedure and is expensive. Discriminatory testing is wasteful. The money spent on it could rather be utilised on education and information on AIDS. (Cameron: 1991)

Despite the very strong arguments against HIV pre-employment screening for everyone, approximately one third of the respondents stated that it is "**practical**" to undertake this in their workplace.

(ii) The employment of an HIV-positive applicant.				
1	2	3	4	5
1.81%	18.48%	33.33%	26.45%	19.93%
				100%

n=276

TABLE 23: THE EMPLOYMENT OF AN HIV-POSITIVE APPLICANT

This highly contentious issue follows on from the pre-employment testing issue. The responses to this statement, shown in Table 23, were varied:

46.38% of the respondents stated that it is "**impractical**" for their companies to employ an applicant with the HIV virus. This is despite all the available information concerning AIDS clearly showing that there is minimal risk of being infected with HIV during normal work activity, and HIV/AIDS generally not being considered an appropriate employment factor. The job performance of such an applicant need not be affected for up to ten years.

Therefore, the reasons behind the "impractical" response need to be understood and overcome in order to 'protect the human rights and dignity of HIV-infected people ...to avoid discriminatory action against, and stigmatisation of them...' (WHO: 1988).

33.33% responded "unsure".

20.29% of the respondents consider it "**practical**" to employ an applicant with the HIV virus.

(iii) The counselling of all applicants/employees tested for the HIV virus.				
1	2	3	4	5
23.91%	39.13%	13.04%	15.94%	7.98%
				=100%

n=276

TABLE 24: COUNSELLING ALL THOSE TESTED FOR HIV

Table 24 shows that 63.04% of the respondents regard this as "**practical**" within their company. Pre and post test counselling is recommended (for example, GASA: 1988, WHO: 1988), owing to the devastating effect a positive result can have on every aspect of the person's life.

23.92% of the respondents replied "**impractical**".

(iv) Gaining the consent of all those tested for the HIV virus.				
1	2	3	4	5
22.43%	**31.25%**	23.53%	14.71%	8.08%
				=100%

n=272

TABLE 25: GAINING CONSENT BEFORE TESTING

Owing to the possible consequences (social, emotional, financial) of being tested for the HIV-antibody status, testing should not be conducted without the voluntary, fully informed **consent** of the employee. This is the view held by many local and internationally recognised bodies. (For example, the AIDS Information Centre in Johannesburg, as well as the WHO.) Despite this being an internationally held view, Table 23 shows that only 53.68% of the respondents replied that it is "**practical**" to implement this in their workplace.

A similar percentage of the respondents stated "**impractical**" (22.79%) and "**unsure**" (23.53%).

> 'Applicants should be informed if general medical tests will include AIDS tests. If they are not informed and an AIDS test is done without their knowledge, a case may be made out for the applicants' privacy having been invaded which may result in civil liability.' (Van Wyk: 1990)

Testing without consent may be especially devastating when an employer has unilaterally incorporated an AIDS termination clause whereby all employees who may at any stage contract HIV-infection, may be dismissed.

Summary

This section has covered Pre-employment AIDS issues. Unlike section 7.2(a), the findings in 7.2(b) show that the responses to these issues are varied.

This concludes section 7.2 (b): "Pre-employment AIDS Policy Issues". An overall assessment of this section is discussed in terms of the main and sub hypotheses in the overall conclusion to chapter 7. (7.4)

Section 7.2(c) which follows, continues with **specific** AIDS policy issues: **"During Employment" Procedures.**

(c) "During Employment" AIDS Policy Issues

The purpose of section 7.2(c) is to determine the "During Employment" Policy issues which the respondents consider practical to implement in their workplace: (see Questionnaire, appendix A)

They include:

(i) Treating employees with the HIV virus equally

(ii) Employees and routine HIV tests

(iii) Maintaining the confidentiality of employees with the HIV virus

(iv) Continued employment of HIV-positive employees

(v) Not reassigning HIV-positive employees to duties which require little human interaction

(vi) Disciplinary action against co-workers who refuse to work with an HIV-positive employee

(vii) The establishment of active safety committees

and

(viii) Trade union involvement in AIDS-related issues

(ix) An AIDS Consultancy assisting management

(x) Joint corporate and community AIDS programmes

The implications of the responses to each of the issues above shall be discussed.

(i) An AIDS policy stating that an HIV-positive employee will be treated no differently to any other employee.				
1	2	3	4	5
22.74%	**38.27%**	22.38%	13.00%	3.61%
				100%

n=277

TABLE 26: AN AIDS POLICY STATING THAT AN HIV-POSITIVE EMPLOYEE WILL BE TREATED THE SAME AS OTHER EMPLOYEES

The implication of such a policy is two-fold: Employee benefits and continued employment. The WHO and ILO Resolution on AIDS in the Workplace (1988) (see appendix B), states that HIV-positive employees should not be discriminated against including access to and receipt of benefits from statutory social security programmes and occupationally related schemes. Furthermore it states that employment should continue without change as long as persons with HIV-related illnesses are medically fit to work.

Table 26 shows that 61.01% of the respondents consider the statement **"An AIDS policy stating that an HIV-positive employee will be treated no differently to any other employee",** to be "**practical**" to implement in their workplace.

There seems to be a fair amount of **uncertainty** surrounding **this** issue (22.38%). To a lesser extent, some respondents **replied "impractical"**: (16.61%) They believe that an HIV-positive employee should be treated differently.

> 'Decisions will have to be taken about affordable services and who will bear the burden of rising costs. As far as the employer's policy regarding sick leave and disability are concerned, AIDS should be ideally dealt with in the same manner as any other chronic and terminal illnesses.' (Van Wyk: 1990)

Question 49 was designed in order to provide greater insight into **Employee Benefits and HIV-positive employees.**

The respondents were asked to **rank** three statements relating to HIV-positive employees and employee benefit packages, first in order of preference, and second in order of practicality.

The following findings emerge:

	1st PREFERENCE	1st PRACTICALITY
Statement A:	11.7%	18.4%
Statement B:	36.8%	37.4%
Statement C:	12.4%	17.4%
Statement D:	39.1%	26.8%
	100%	100%
	n=266	n=265

TABLE 27: STATEMENTS RELATING TO EMPLOYEE BENEFITS RANKED IN ORDER OF 1st PREFERENCE AND 1st PRACTICALITY

Key:

Statement A: Employees are justified in excluding HIV-positive employees from benefit policies.

Statement B: Through negotiation, a company-specific AIDS-related benefits policy should be developed.

Statement C: An HIV-positive applicant should be employed with limited benefits (specified by the insurance company).

Statement D: HIV-positive employees should be treated in the same manner as all other employees.

From Table 27 it can be deduced that:

Statement D received the strongest response for "1st Preference" (39.1%). Less respondents stated that this was "1st in Practicality" (26.8%).

Statement B received the strongest response for "1st in Practicality" (37.4%). A similar percentage ranked this statement "1st in Preference" (36.8%).

Therefore, Statement B: "Through negotiation, a company-specific AIDS-related benefits policy should be developed", received a strong response for both "preference" and "practical".

	2nd PREFERENCE	2nd PRACTICALITY
Statement A:	9.16%	14.5%
Statement B:	42.63%	35.7%
Statement C:	29.88%	30.9%
Statement D:	18.33%	18.9%
	100%	100%
	n=251	n=249

TABLE 28: STATEMENTS RELATING TO EMPLOYEE BENEFITS RANKED IN ORDER OF 2nd PREFERENCE AND 2nd PRACTICALITY

Table 28 shows that Statement B received the strongest response for "2nd Preference" (43%) and "2nd in Practicality" (36%). This reinforces the finding above.

Statement C: "An HIV-positive applicant should be employed with limited benefits (specified by the insurance company)" received the second strongest response for "2nd Preference" (30%) and "2nd in Practicality" (31%). This statement implies restricting the benefits of an applicant with HIV, which many consider discriminatory. Despite this, these respondents stated that such an applicant **should** be employed.

The majority of the respondents consider Statement A the **least** preferable and practical statement: "Employees are justified in excluding HIV-positive employees from benefit policies".

(ii) Persuading employees to have routine HIV tests.				
1	2	3	4	5
9.05%	26.09%	21.38%	**31.16%**	**12.32%**
				100%

n=276

TABLE 29: PERSUADING EMPLOYEES TO HAVE ROUTINE HIV TESTS

> 'In some cases it will already be part of the employee's contract of employment that he should submit to periodical medical tests. The introduction of an AIDS test into a general examination may, depending ,on the circumstances, constitute an unfair unilateral amendment of the terms of the Labour Relations Act.' (Van Wyk: 1990)

The responses to the statement in Table 29 are varied:

Only 43.48% of the respondents answered that persuading employees to have routine HIV tests is "**impractical**" in their workplace.

35.14% responded that this is "**practical**" to implement in their workplace.

Once again uncertainty appears to exist (21.38%).

(iii) Maintaining the confidentiality of an HIV-positive employee.				
1	2	3	4	5
34.06%	**43.12%**	12.32%	7.25%	3.25%
				100%

n=276

TABLE 30: MAINTAINING THE CONFIDENTIALITY OF AN HIV-POSITIVE EMPLOYEE

Table 30 shows that the majority of the respondents consider it "**practical**" to maintain the confidentiality of an HIV-positive employee, in their workplace. This is in

accordance with the WHO recommendation that: 'Confidentiality regarding all medical information, including HIV/AIDS status, must be maintained'. (WHO: 1988)

> 'AIDS is not a notifiable disease and therefore no statutory duty exists to provide justification for the disclosure of confidential information. No justification for the disclosure on account of the social interest exists in the normal workplace, with the exception again of work of a medical or emergency nature.' (Van Wyk: 1990)

(iv) Not terminating the services of an HIV-positive employee.

1	2	3	4	5
12.00%	**41.09%**	30.91%	11.27%	4.73%
				100%

n=275

TABLE 31: NOT TERMINATING THE SERVICES OF AN EMPLOYEE WITH HIV

> 'When an employee becomes HIV-positive, it may take years before he becomes incapable of doing his work and during this time he need not inform his employer, except if he constitutes a health threat. However when the employee is no longer capable of doing his job, there is a duty upon him to inform his employer. Failure to do this may make dismissal possible. To dismiss a worker from the normal workplace merely as a result of his HIV infection, would probably be regarded by the industrial court as an unfair labour practice.' (Van Wyk: 1990)

From Table 31, it can be seen that 53.09% of the respondents consider it "**practical**" not to terminate the services of an HIV-positive employee in their workplace merely because he/she tested HIV-antibody positive.

(v) Reassigning all the HIV-positive employees to duties which eliminate the need for human interaction.

1	2	3	4	5
4.00%	13.09%	17.09%	**44.00%**	**21.82%**
				100%

n=275

TABLE 32: REASSIGNING ALL EMPLOYEES WITH HIV TO DUTIES WHICH ELIMINATE THE NEED FOR HUMAN INTERACTION

Table 32 shows that 65.82% of the respondents consider it "**impractical**" to implement this in their workplace. This is in accordance with the WHO recommendation that an employee who is infected with the HIV virus does not constitute sufficient grounds for assigning him/her to duties that eliminate the need for human interaction. (WHO: 1988)

(However, if the employee works in an area where he/she may be a hazard owing to possible injury (eg: dangerous machinery), the employee should be relocated to another area of work.)

> 'Infected persons can be discriminated against by being demoted or laid off duties.... Given the facts about HIV/AIDS it seems clear that demotion or transfer unrelated to specific medical incapacity would both at common law and under the post-1988 and post-1991 unfair labour practice definitions, be impermissable and thus actionable.' (Cameron: 1991)

The same percentage of respondents answered "**unsure**" (17.09%) and "**practical**" (17.09%).

(vi) Disciplinary action against co-workers who, (after AIDS education sessions), refuse to work with an HIV-positive employee.

1	2	3	4	5
1.82%	21.09%	35.27%	**27.27%**	**14.55%**
				100%

n=275

TABLE 33: DISCIPLINARY ACTION AGAINST CO-WORKERS WHO REFUSE TO WORK WITH AN HIV-POSITIVE EMPLOYEE

The findings in Table 33 indicate that 41.82% of the respondents consider it "**impractical**" to implement such disciplinary action in their workplace. This is contrary to the WHO recommendation (WHO: 1988).

> '...If employees still refuse to work with an HIV-positive employee, disciplinary action against them is possible...' (Van Wyk: 1990)

> 'It thus seems certain that the law will not tolerate irrational, unreasonable or absurd conduct...' (Cameron: 1991)

Cameron states that an AIDS policy should make:

> 'irrational co-employee reaction to HIV positivestatus - rather than the status itself - the focus of remedial response:' (Cameron: 1991)

To a slightly lesser extent, the respondents answered "**unsure**" (35.27%). A minority of the respondents responded "practical". (22.91%).

(vii) The establishment of an active safety committee comprising of management.				
1	2	3	4	5
12.82%	**44.69%**	17.58%	20.51%	4.40%
				100%
(viii) The establishment of an active safety committee comprising of management and employee representatives.				
1	2	3	4	5
19.34%	**58.03%**	12.41%	7.66%	2.56%
				100%

n=274

TABLE 34: THE ESTABLISHMENT OF AN ACTIVE SAFETY COMMITTEE

Table 34 shows that a safety committee comprising of management and employee representatives is regarded as considerably more "**practical**" to implement in their workplace (77.37%) than a management only committee (57.51%).

> 'It is the common-law duty of the employer to provide safe working conditions for his employees. Employees contracting AIDS in the course of employment may, depending on the procedure adopted by the employer and fellow employees, be able to bring commom-law action against their employer for negligence. The employer must provide safe working conditions.
>
> Therefore, the reasonable steps the employer should take to exclude fault or negligence, relate to a safe system, safe premises, and a safe plant. A safe system includes competent personnel and, where health care workers are involved, the employer has a duty to ensure that they are adequately instructed on how to avoid contracting HIV, to provide them with the necessary safety precautions which should become routine for all workers. ...If infection takes place during the execution of the employees duties, the employer may be held responsible...' (Van Wyk: 1990)

(ix) Increasing the awareness of trade unions about "AIDS in the Workplace" issues.				
1	2	3	4	5
18.08%	**53.51%**	16.61%	7.38%	4.42%
				100%

n=271

TABLE 35: INCREASING THE AWARENESS OF TRADE UNIONS ABOUT AIDS-RELATED WORKPLACE ISSUES

The findings in Table 35 indicate that 71.59% of the respondents consider "increasing the awareness of trade unions about AIDS in the Workplace issues" "**practical**" to implement in their workplace.

(x) An "AIDS in the Workplace" consultancy making companies more aware of the potential implications of AIDS in the workplace.				
1	2	3	4	5
14.18%	**57.73%**	17.18%	8.00%	2.91%
				100%
(xi) An "AIDS in the Workplace" consultancy assisting companies with their preventative AIDS measures. (policy/education)				
1	2	3	4	5
16.42%	**58.39%**	16.79%	6.21%	2.19%
				100%

n=275

TABLE 36: THE ESTABLISHMENT OF AN "AIDS IN THE WORKPLACE" CONSULTANCY

Table 36 shows that over 70% of the respondents stated that it is "**practical**" to have an AIDS consultancy increasing the "AIDS" awareness as well as assisting them in their "AIDS" efforts.

(xii) Joint corporate-community AIDS programmes.				
1	2	3	4	5
8.73%	**43.64%**	30.54%	12.00%	5.09%
				100%
(xiii) "Bigger business" assisting "smaller business" with their preventative AIDS programmes.				
1	2	3	4	5
5.82%	**38.91%**	36.72%	12.73%	5.82%
				100%

n=275

TABLE 37: CO-ORDINATION OF BUSINESSES AND COMMUNITY PREVENTATIVE AIDS EFFORTS

Table 37 indicates that just over half (52.37%) of the respondents consider "corporate-community" AIDS programmes with respect to their workplace, "**practical**" to implement.

> 'Instead of seeking only to minimise the impact of HIV and AIDS will have on their particular enterprises, employers should join in the national effort to control the disease through information, education and compassionate treatment of those already infected by it.' (Cameron: 1991)

30.54% responded "**unsure**".

Less than half of the respondents (44.73%) consider larger businesses assisting smaller businesses with their preventative AIDS measures to be "**practical**". Many of the respondents answered "**unsure**".(36.72%)

Summary

Section 7.2(c) has covered "during employment AIDS issues". Many of the statements received varied responses. These responses have been analysed and the implications discussed. This discussion has provided insight into the preventative AIDS procedures respondents from the sample companies in South Africa perceive practical to implement in their workplace, and how this corresponds to world and local opinion.

This concludes section 7.2: "During Employment" AIDS Policy Issues. An overall assessment of this section is discussed in terms of the main and sub hypotheses in the overall conclusion to chapter 7. (7.4)

Section 7.3 which follows, continues with the investigation into the preventative AIDS efforts which the respondents consider practical to implement in their workplace. It focuses on the pivotal issue of: **Workplace Preventative AIDS Education.**

7.3 Workplace Preventative AIDS Education:

Workplace Preventative AIDS Education is the second pillar supporting a company's preventative AIDS efforts. This section is divided into two parts: (see Questionnaire: appendix A)

(a) Educating about AIDS

(b) Features of a Workplace AIDS Education Programme

As mentioned (section 7.1), in this section of the questionnaire respondents were required to express their opinion on the issues which follow. These opinions may or may not reflect the views of the company. Furthermore, the discussion which follows is based on the answers of the respondents and interpretation by the author who has had extensive discussion with opinion leaders in AIDS-related fields.

(a) Educating About AIDS:

The purpose of section 7.3(a) is to establish:

- Whether it is "practical" to undertake AIDS education in the workplace
- Which spheres of a company are considered practical to involve in the workplace AIDS education

(i) Undertaking preventative AIDS education in the workplace.				
1	2	3	4	5
36.23%	**52.17%**	5.44%	4.71%	1.45%
				100%

n=276

TABLE 38: UNDERTAKING A PREVENTATIVE AIDS EDUCATION PROGRAMME IN THE WORKPLACE

The findings in Table 38 indicate that majority of the respondents stated that it is "**practical**" to undertake preventative AIDS education in their workplace. (88.40%)

(ii) Educating management about AIDS-related workplace issues.				
1	2	3	4	5
44.76%	**49.09%**	2.52%	3.24%	0.39%
				100%
(iii) Educating employee representatives about AIDS-related workplace issues.				
1	2	3	4	5
22.10%	**58.70%**	11.96%	6.16%	1.08%
				100%

n=277

TABLE 39: EDUCATING MANAGEMENT AND EMPLOYEE REPRESENTATIVES ABOUT AIDS-RELATED WORKPLACE ISSUES

Table 39 shows that most of the respondents consider educating management (93.85%) and employee representatives (80.8%) about AIDS-related workplace issues to be "**practical**" to implement in their workplace.

(iv) The "training of preventative AIDS educators" how to educate about AIDS-related workplace issues.				
1	2	3	4	5
22.74%	**48.38%**	15.16%	11.55%	2.17%
				100%

n=277

TABLE 40: TRAINING "PREVENTATIVE AIDS EDUCATORS" HOW TO EDUCATE

Table 40 shows that 71.12% of the respondents consider the training of "preventative AIDS educators" how to educate about AIDS-related Workplace issues, to be "**practical**" to implement in their workplace.

(v) Family Planning clinics having a role to play in the preventative AIDS education.				
1	2	3	4	5
46.55%	**42.55%**	6.55%	3.26%	1.09%
				100%

n=275

TABLE 41: THE INVOLVEMENT OF FAMILY PLANNING CLINICS IN THE PREVENTATIVE AIDS EDUCATION

Table 41 shows that an overwhelming majority of the respondents (89.1%) stated that it is "**practical**" to involve family planning clinics in their workplace preventative AIDS education.

(vi) The development of a network of employees, educated about AIDS.				
1	2	3	4	5
16.24%	**49.09%**	23.82%	10.10%	0.75%
				100%

n=277

TABLE 42: THE DEVELOPMENT OF A NETWORK OF EMPLOYEES EDUCATED ABOUT AIDS

Table 42 shows that 65.22% of the respondents consider the development of a network of employees educated about AIDS practical to implement in their workplace.

Question 50 was designed in order to gain more insight into the **different spheres of a company which should be involved in the Preventative AIDS Education.** (The complete frequency tables from which Table 43 is derived, is shown in appendix MM.)

The respondents were asked first to **rank** "in order of importance", and second "in order of practicality in their workplace", who they felt should be involved in the preventative AIDS education.

	1st IMPORTANCE	1st PRACTICALITY
Top Management/ Management	**46.03%**	25.75%
Personnel/Human Resources	16.60%	27.27%
Occupational Health/ Medical People	31.69%	**38.25%**
	n=265	n=264

TABLE 43: MEMBERS OF THE COMPANY RANKED "FIRST MOST IMPORTANT" AND "FIRST MOST PRACTICAL "WITH RESPECT TO AIDS EDUCATION

Table 43 shows the members of the company who **received the strongest responses** for "1st" in the importance rankings and "1st" in terms of practicality.

Top management/management as members of the company involved in the AIDS education received the strongest response for "1st" in the **importance rankings.** (46.03%). 25.75% of the respondents ranked top management/management involvement in education "1st" in terms of practicality in the workplace.

Table 43 shows that **occupational/medical** people being involved in the AIDS education received the strongest response to "1st" in terms of practicality (38.25%).

31.69% of the respondents consider occupational health/medical people being involved in the AIDS education "1st" in terms of importance. This is the second strongest response.

Personnel/Human Resources being involved in the AIDS education are considered by 16.6% of the respondents to be "1st" in terms of importance, and by 27.27% of the companies to be "1st" in terms of **practicality.**

With respect to the **rankings** of "2nd important and practical", **personnel/human resources** received the strongest responses: 27.69% responded "important", 35.14% responded "practical". Therefore, a similar percentage of respondents believe that the involvement of personnel/human resources in the AIDS education is both important and practical.

An interesting finding is that **unions/employee representatives** received strong responses in the second, third and fourth "important" (2nd: 16.54%, 3rd: 23.32%, 4th: 27.05%), and "practical" (2nd: 18.53%, 3rd: 24.80%, 4th: 22.83%) rankings.

Overall, personnel/human resources, top management, unions/employee representatives and occupational health/medical people received the strongest responses in the "**important**" and "**practical**" rankings.

Summary

The findings from section 7.3(a) show that the majority of the respondents regard undertaking AIDS education to be "**practical**". Furthermore, the respondents appear to recognise the importance and "practicality" of involving **management, employee representatives, personnel/human resources** and **occupational health/medical/ family planning staff**, in order to achieve an "**AIDS-educated**" **employee body.**

There is therefore more concensus regarding AIDS education than the previous issue concerning a workplace AIDS policy approach - both pre-employment and during employment. (7.2(a) and (b))

Section 7.3(b) which follows continues with an investigation into **"Practical Features of a Preventative AIDS Education Programme".**

(b) Features of a Preventative AIDS Education Programme:

The aim of Section 7.3(b) is to:

- Establish what "practical" features a preventative AIDS education programme for **management, employee representatives and employees** should involve.
- Ascertain whether it is practical for these groups to have **different forms of education.**
- Determine whether these "practical" AIDS education programmes need to be **tailored according to the needs, values, attitudes and backgrounds of the different audiences.**

As the findings which follow highlight, with one slight exception, all the features of a preventative AIDS education programme are considered practical by over 70% of the respondents.

These features will now be discussed in more detail.

Once again the respondents are expressing opinions which may or may not reflect the views of the company. The discussion which follows is based on these responses and augmented by the interpretations of the author.

(i) Ongoing Education:

	Management	Employee Reps	Employees
"**Practical**"	78.31%	79.37%	84.62%
"Unsure"	11.40%	11.11%	7.29%
"Impractical"	10.29%	9.52%	8.09%
	100%	100%	100%
	n=272	n=252	n=247

TABLE 44: ONGOING AIDS EDUCATION FOR MANAGEMENT, EMPLOYEE REPRESENTATIVES, AND EMPLOYEES

Table 44 shows that over 78% of the respondents consider ongoing AIDS education for management, employee representatives and employees to be "**practical**" to implement in their workplace.

(ii) Presents Facts, Dispels Myths:

	Management	Employee Reps	Employees
"**Practical**"	90.44%	86.05%	89.46%
"Unsure"	8.46%	9.96%	7.29%
"Impractical"	1.10	3.99	3.25%
	100%	100%	100%
	n=272	n=251	n=247

TABLE 45: AIDS EDUCATION WHICH PRESENTS THE FACTS TO MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES

From Table 45 it can be seen that over 86% of the respondents consider preventative AIDS education in the workplace which presents the facts and dispels the myths, "**practical**" to implement in their workplace for management, employee representatives and employees.

(iii) Not Too Time Consuming:

	Management	Employee Reps	Employees
"**Practical**"	73.89%	73.70%	74.08%
"Unsure"	18.38	18.33%	17.41%
"Impractical"	7.73%	4.97%	8.51%
	100%	100%	100%
	n=272	n=251	n=247

TABLE 46: AIDS EDUCATION WHICH IS NOT TOO TIME CONSUMING FOR MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES

(iv) During Company Time:

	Management	Employee Reps	Employees
"**Practical**"	81.25%	78.88%	77.38%
"Unsure"	9.56%	12.35%	14.58%
"Impractical"	9.19%	8.77%	8.04%
	100%	100%	100%
	n=272	n=251	n=247

TABLE 47: AIDS EDUCATION WHICH IS DURING COMPANY TIME FOR MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES

Table 46 shows that most of the respondents (approximately 74%) stated that AIDS education programmes which are not too time consuming, are "**practical**" to implement in their workplace with respect to management, employee representatives and employees.

From Table 47 it can be seen that the majority of the respondents (over 77%) consider AIDS education programmes **during** company time to be practical to implement in their workplace for management, employee representative and employees. This is in accordance with the WHO Concensus statement 1988 where there was general agreement that provision of information within working hours would enhance the effect of an AIDS education programme. The need for commitment and co-operation between management and unions was stressed.

(v) Communication Through a Multi-Channel Network:

	Management	Employee Reps	Employees
"**Practical**"	70.11%	68.00%	69.23%
"Unsure"	18.08%	20.40%	19.03%
"Impractical"	11.81%	11.60%	11.74%
	100%	100%	100%
	n=271	n=250	n=247

TABLE 48: AIDS EDUCATION WHICH IS COMMUNICATED THROUGH A MULTI-CHANNEL COMMUNICATION NETWORK TO MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES

The findings in Table 48 indicate that many of the respondents consider it "**practical**" to communicate the AIDS education through a multi-channel communication network to management (70.11%), employee representative (68.00%), and employees (69.23%).

(vi) Emphasise Company Policy:

	Management	Employee Reps	Employees
"**Practical**"	84.50%	79.92%	83.67%
"Unsure"	11.81%	14.46%	12.25%
"Impractical"	3.69%	5.62%	4.08%
	100%	100%	100%
	n=271	n=249	n=245

TABLE 49: AIDS EDUCATION WHICH EMPHASISES COMPANY POLICY TO MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES

Table 49 shows that emphasising the company AIDS policy in the AIDS education to management, employee representatives and employees is considered "**practical**" to implement in their workplace by the majority of the respondents (more than 80%).

(vii) Highlight Medical Facts:

	Management	Employee Reps	Employees
"Practical"	89.29%	87.60%	88.61%
"Unsure"	8.49%	8.80%	8.13%
"Impractical"	2.22%	3.60%	3.26%
	100%	100%	100%
	n=271	n=250	n=246

TABLE 50: AIDS EDUCATION WHICH HIGHLIGHTS THE MEDICAL FACTS TO MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES

From Table 50 it can be seen that most of the respondents (over 87%) consider it "practical" to emphasise the medical facts when educating management, employee representatives and employees about AIDS in their workplace.

(viii) Educate About Safer Sex:

	Management	Employee Reps	Employees
"Practical"	81.91%	86.00	87.80%
"Unsure"	9.23%	10.00%	7.32%
"Impractical"	8.86%	4.00%	4.88%
	100%	100%	100%
	n=271	n=250	n=246

TABLE 51: AIDS EDUCATION WHICH EDUCATES MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES ABOUT SAFER SEX.

Table 51 shows that most (over 81%) of the respondents consider educating management, employee representatives and employees about safer sex to be "practical" to implement in an AIDS education programme in their workplace.

(ix) Counter Fear and Anxiety:

	Management	Employee Reps	Employees
"**Practical**"	86.00%	83.60%	86.00%
"Unsure"	11.07%	11.60%	10.98%
"Impractical"	3.33%	4.80%	3.02%
	100%	100%	100%
	n=271	n=250	n=246

TABLE 52: AIDS EDUCATION FOR MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES WHICH COUNTERS FEAR AND ANXIETY

From Table 52 it can be seen that the majority of the respondents (more than 83%), consider an AIDS education programme for management, employee representatives and employees, which counters fear and anxiety "**practical**" to implement in their workplace.

(x) Provide Information on Company Facilities Regarding AIDS Prevention:

	Management	Employee Reps	Employees
"**Practical**"	85.50%	100.00%	100.00%
"Unsure"	10.41%	0.00%	0.00%
"Impractical"	4.09%	0.00	0.00%
	100%	100%	100%
	n=271	n=250	n=246

TABLE 53: A MANAGEMENT, EMPLOYEE REPRESENTATIVE AND EMPLOYEE AIDS EDUCATION PROGRAMME WHICH PROVIDES INFORMATION ON COMPANY FACILITIES REGARDING AIDS PREVENTION

The findings in Table 53 indicate that almost all the respondents consider it "**practical**" to provide information on their company facilities regarding AIDS prevention to management, employee representatives and employees.

(xi) Provide Pamphlets To Take Home:

	Management	Employee Reps	Employees
"**Practical**"	91.91%	90.83%	91.86%
"Unsure"	4.78%	6.78%	5.29%
"Impractical"	3.31	2.39%	2.85%
	100%	100%	100%
	n=272	n=251	n=246

TABLE 54: A MANAGEMENT, EMPLOYEE REPRESENTATIVE AND EMPLOYEE AIDS EDUCATION PROGRAMME WHICH PROVIDES PAMPHLETS TO TAKE HOME

Table 54 shows that almost all the respondents (over 90%) consider it "**practical**" to provide management, employees and employee representatives with pamphlets to take home.

(xii) Be Linked to Relevant External Bodies, Community Services

	Management	Employee Reps	Employees
"**Practical**"	79.04%	100.00%	100.00%
"Unsure"	15.44%	0.00%	0.00%
"Impractical"	5.52%	0.00%	0.00%
	100%	100%	100%
	n=272	n=251	n=246

TABLE 55: A MANAGEMENT, EMPLOYEE REPRESENTATIVE AND EMPLOYEE AIDS EDUCATION PROGRAMME WHICH IS LINKED TO RELEVANT EXTERNAL BODIES, COMMUNITY SERVICES

Table 55 indicates that the majority of the respondents consider an AIDS education programme which is linked to external/community bodies to be "**practical**" for management (79%), employee representative (100%) and employees (100%).

In terms of the aims of Question 45a, 45b and 45c, the following emerges:

(a) All the features of a preventative AIDS education programme as discussed are considered practical by the majority of the respondents

(b) These features are considered practical for a management, employee representative and employee AIDS education programme

(c) The third aim was to establish whether the AIDS education programmes needed to be tailored according to the audiences' needs, values and backgrounds: The strong "practical" response to the following statements is therefore highly significant.

- **Tailored According to the Needs, Attitudes, Values, Cultures of the Audience:**

	Management	Employee Reps	Employees
"Practical"	84.58%	100.00%	100.00%
"Unsure"	11.03%	0.00%	0.00%
"Impractical"	4.39%	0.00%	0.00%
	100%	100%	100%
	n=272	n=251	n=246

TABLE 56: AN AIDS EDUCATION PROGRAMME FOR MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES TAILORED ACCORDING TO THE NEEDS, VALUES AND CULTURES OF THE AUDIENCE

- **Aware of Different Education and Socio-economic Levels:**

	Management	Employee Reps	Employees
"Practical"	84.13%	100.00%	81.78%
"Unsure"	11.44%	0.00%	13.36%
"Impractical"	4.43%	0.00%	4.86%
	100%	100%	100%
	n=271	n=251	n=247

TABLE 57: AN AIDS EDUCATION PROGRAMME FOR MANAGEMENT, EMPLOYEE REPRESENTATIVES AND EMPLOYEES WHICH IS AWARE OF DIFFERENT EDUCATION AND SOCIO-ECONOMIC LEVELS

The findings in Tables 56 and 57 show that the majority of the respondents (over 80%) stated that an AIDS education programme which is tailored according to the needs, attitudes, values, cultures, education and socio-economic levels of the audience, for management, employee representatives and employees is "**practical**".

Summary

This section not only highlights the positive response of the respondents towards a preventative AIDS education programme, but provides valuable input into the recommendations (chapter 9): Areas for Future Research: Practical Guidelines to a Social Marketing Preventative AIDS Action Plan.

This concludes section 7.3: "Workplace Preventative AIDS Education". An assessment of this section is discussed in terms of the main and sub hypotheses in the overall conclusion to chapter 7. (7.4)

The conclusion to Chapter 7 follows.

7.4 Conclusion

Sections 7.2 and 7.3 concentrated on a number of statements regarding general workplace AIDS issues, pre-employment and "during employment" AIDS issues, as well as matters concerning workplace preventative AIDS education. The findings to these statements have been analysed, and the implications discussed.

The purpose of section 7.4 is to evaluate this analysis and discussion in the light of the objectives and therefore main and sub hypotheses stated in chapter 1.

Main Hypothesis:

$H_{o(1)}^{(a)}$: **The respondents consider it impractical to undertake preventative AIDS provisions (policy and education) in their workplace.**

This hypothesis is **not supported** by the findings.

An overwhelming majority of the respondents (88%) consider the undertaking of preventative AIDS provisions (policy/education) in the workplace, before HIV-related issues arise, to be **practical.** (section 7.2(a))

This finding is consistent with world and local opinion that companies should prepare for the impact of AIDS. Being prepared involves developing an AIDS policy and education programme.

(B)
Sub Hypothesis: $H_{o(1)}$

(B)
$H_{o(1)}$ **The respondents are not all in agreement with respect to their overall approach to HIV pre-employment issues.**

The findings **support** this hypothesis.

The findings in section 7.2(b) show that there are varying degrees of agreement with respect to the four statements:

- "The **counselling** of all applicants/employees tested for the HIV virus" statement received the most agreement. (63% responded "practical")

- 54% of the respondents consider "HIV-antibody **pre-employment screening** for everyone" to be **impractical**, and "Gaining the **consent** of all those tested for the HIV virus", to be **practical**. Therefore, with respect to these contentious pre-employment procedures, the respondents do not exhibit an overall common approach.

- The results show that the respondents are least equal in their approach towards "The **employment of an HIV-positive applicant**". (43% responded impractical)

It can therefore be **concluded** that the respondents are not all in agreement concerning an approach towards pre-employment AIDS issues.

(B)
Sub Hypothesis: $H_{o(2)}$

(B)
$H_{o(2)}$ **The respondents do not all agree with respect to their approach towards HIV-related "during employment" issues.**

The hypothesis is **supported** by the findings.

Some of the "during employment statements" received strong agreement, while others were varied.

The findings show that only four statements in section 7.2(c) received above 70% agreement:

- Maintaining the **confidentiality** of an employee with the HIV virus (77% responded practical)
- The establishment of a **safety committee** comprising of management and employee representatives (77% responded practical)
- Increasing the awareness of **trade unions** about "AIDS in the Workplace" issues (72% responded practical)
- An "AIDS in the Workplace" **consultancy** assisting companies with their preventative AIDS measures (74% responded practical)

The strongest response to each of the following statements was less than 70% :

- **Reassigning** all the HIV-positive employees to duties which eliminate the need for human interaction (66% responded impractical, 17% unsure)
- An AIDS policy stating that an HIV-positive employee will be **treated no differently** to any other employee (61% responded practical, 22% unsure)

- **Not terminating** the services of an HIV-positive employee (53% practical, 31% unsure)

- Joint **corporate-community** AIDS programmes (52% responded practical, 31% unsure)

- "**Bigger business" assisting "smaller business**" with their preventative AIDS programmes (44% responded practical, 37% unsure)

- Persuading employees to have **routine HIV tests** (43% responded impractical, 21% unsure)

- **Disciplinary action** against co-workers who (after AIDS education sessions), refuse to work with an HIV-positive employee (42% responded impractical, 35% unsure)

From the findings in section 7.2(c), it can be **concluded** that there is no overall consistent approach by the respondents to the majority of statements relating to "during employment" AIDS procedures.

(B)

$H_{o(3)}$ The respondents do not consider a thorough preventative AIDS education programme practical to implement in their workplace.

The findings **do not support** this hypothesis.

The findings have shown:

1. The majority of the respondents consider it practical to involve management, employee representatives, personnel/human resources, occupational health/ medical/family planning staff in their AIDS education programme in order to achieve a network of educated employees.

2. The majority of the respondents consider the features of an AIDS education programme which are listed in the questionnaire, practical to implement in their workplace. Together, these features should form the basis of a thorough AIDS education programme.

In conclusion, the results and discussions in Chapter 7 have shown that the respondents **do** consider it practical to undertake preventative AIDS efforts in the workplace: They **do not agree** with respect to an overall approach to pre-employment and "during employment" AIDS issues. They **do** regard the undertaking of an AIDS education programme in the workplace to be practical.

CHAPTER EIGHT

OVERALL CONCLUSIONS

8.1 Introduction

Chapter 8 is concerned with **bringing together** the trends which have emerged from this study. Together they form the foundation of the recommendations. (chapter 9) A brief discussion on the implications of the research findings and discussions, and literature review follow.

8.2 Implications of the Research Findings and Discussions: Chapter 6:

Chapter 6 involved an investigation into the preventative AIDS efforts which the companies in the sample have undertaken. This provided an understanding of **what** some South African companies have done with respect to AIDS prevention in the workplace, and **how** they have gone about it. This in turn has provided a solid base from which the recommendations can flow. The findings **supported** the two main hypotheses - The majority of the companies do not have a formal AIDS policy, nor ongoing AIDS education for management and employees.

The respondents from the companies have given a clear signal that they are willing to further preventative AIDS efforts in their workplace. The **current** preventative AIDS actions by the companies, and what the respondents state they are **prepared** to do, highlight **areas for future research.** (6.17)

8.3 Implications of the Research Findings and Discussions: Chapter 7:

In chapter 7, the findings to the preventative AIDS provisions which the respondents from the companies consider **practical** to implement in their workplace are analysed and discussed. The main hypothesis is **not supported** by the findings - the respondents **do** consider it practical to undertake preventative AIDS provisions (policy and education) in their workplace. **The challenge is to seize this fertile opportunity, and develop a strategy aimed at facilitating the adoption of practical preventative AIDS provisions by companies throughout South Africa.** This challenge is complicated by the respondents' overall lack of agreement with respect to an AIDS policy approach, and is simplified by the "majority practical response" to a thorough preventative AIDS education programme.

8.4 Implications of the Literature Review: Chapters 2,3,4:

In the literature review, the following definition of social marketing was proposed: (section 2.3.1)

> **Social Marketing is concerned with the goals of business and society. It is involved with matters of social concern - it is the marketing of social causes or programmes designed according to current identified and latent needs and wants of the target market(s).**

The literature review concluded that this definition, and the nature of the AIDS prevention challenge in the workplace, demonstrate that AIDS is a just cause for social marketing: Firstly, AIDS is a social concern. By undertaking social marketing preventative AIDS efforts in the workplace, a company is furthering the long term societal goal of preventing the spread of

AIDS, and hence its grave consequences. Secondly, the processes and techniques of social marketing can be applied to these workplace preventative AIDS measures, in order to effectively market this social cause/programme to the target markets.

8.5 Summary

From the research findings and discussions in chapter 6 and 7, arduous challenges have been identified. The solution does not lie simply in recognising these challenges. There is a need for action. Evidence from the literature suggest that social marketing principles and techniques are compatible with the task of AIDS prevention in the Workplace. **It is therefore proposed that a solution to the identified challenges is a Workplace Social Marketing Preventative AIDS Programme.**

CHAPTER NINE

RECOMMENDATIONS

9.1 Introduction

On the basis of the study, chapter 9 highlights areas for future research. Tentative guidelines of an "AIDS Action Plan" are proposed.

This final chapter presents recommendations based on the entire study. It focuses on the application of **social marketing principles** and **techniques** to a Workplace AIDS Prevention Programme.

It is made up of four sections: Social Marketing Principles and a Workplace Preventative AIDS Programme (9.2), Social Marketing Techniques Applied to AIDS Prevention in the Workplace (9.3), Further Directions for Future Research (9.4), and Concluding Remarks (9.5).

9.2 Social Marketing Principles and a Workplace Preventative AIDS Programme.

Social Marketing has an "external nature" to the extent that it is concerned with the goals of society and business. (section 2.3.1)

By undertaking **social marketing** preventative AIDS efforts **internally**, (which the majority of the respondents consider practical to do), companies are not only serving their own needs but are acting in concert with the long term goals of society: Striving towards the containment of the spread of AIDS and its serious impact on all spheres of society.

Section 9.3 proposes how a company can adopt a social marketing approach to AIDS prevention in the workplace.

9.3 Social Marketing Techniques Applied to AIDS Prevention in the Workplace: Social Marketing Guidelines to a Workplace AIDS Action Plan

9.3.1: Introduction

This section focuses on the application of **social marketing techniques** to a Preventative AIDS Programme in the Workplace - **"Guidelines to a Social Marketing AIDS Action Plan".**

These guidelines utilise social marketing 'knowledge, techniques, and technologies (which) now exist to organise and implement effective social change programs...' (Kotler and Roberto: 1989: x)

The "action plan" is discussed in the light of the theory. Extracts from "**Social Marketing - Strategies for Changing Public Behaviour**", a comprehensive guide for planning and effectively implementing social campaigns (**Kotler and Roberto: 1989**), are utilised.

> 'To be effective, social marketers must understand the marketing environment... (The social marketing environment) is the set of forces that are external to the social change campaign and that impinge on its ability to develop and maintain successful influence on its target adopters.' (Kotler and Roberto: 1989:79)

This dissertation has scanned the external social marketing environment relating to AIDS (chapter 5). This provided insight into the medical, demographic, economic, political, legal, industrial relations, and socio-cultural forces surrounding AIDS.

> 'Sound research is the basis of social marketing. Research is what differentiates the marketing approach to social change... . Only by researching and understanding the specific needs, desires, beliefs, and attitudes of target adopters and the specific characteristics of the social products that are being marketed can social marketers move toward the successful implementation of social change campaigns.' Kotler and Roberto: 1989:62)

The guidelines which follow are based on empirical research (chapters 6 and 7). This research provides an understanding of the companies actions and respondents' views with respect to "AIDS-related Workplace issues".

Chapter 6 provided a deep insight into the "Preventative AIDS Efforts" conducted by the companies in the sample

Chapter 7 provided insight into the preventative AIDS measures which the respondents from the companies consider **practical** to implement in their workplace (chapter 7)

9.3.2 Objective of the "AIDS Action Plan"

- To develop **Social Marketing** Guidelines to a Workplace Preventative AIDS Action Plan. This involves developing guiding principles to a comprehensive **AIDS Policy** and **Preventative AIDS Education Programme.**

AIDS will not represent a threat for the companies which are prepared: The "action plan" facilitates the preparation process.

> 'Social marketers will develop an integrated social marketing plan whose mix of elements is coherent and appealing to the target adopters.' (Kotler and Roberto: 1989:275)

The following figure represents the integrated Social Marketing AIDS Action Plan which has been developed.

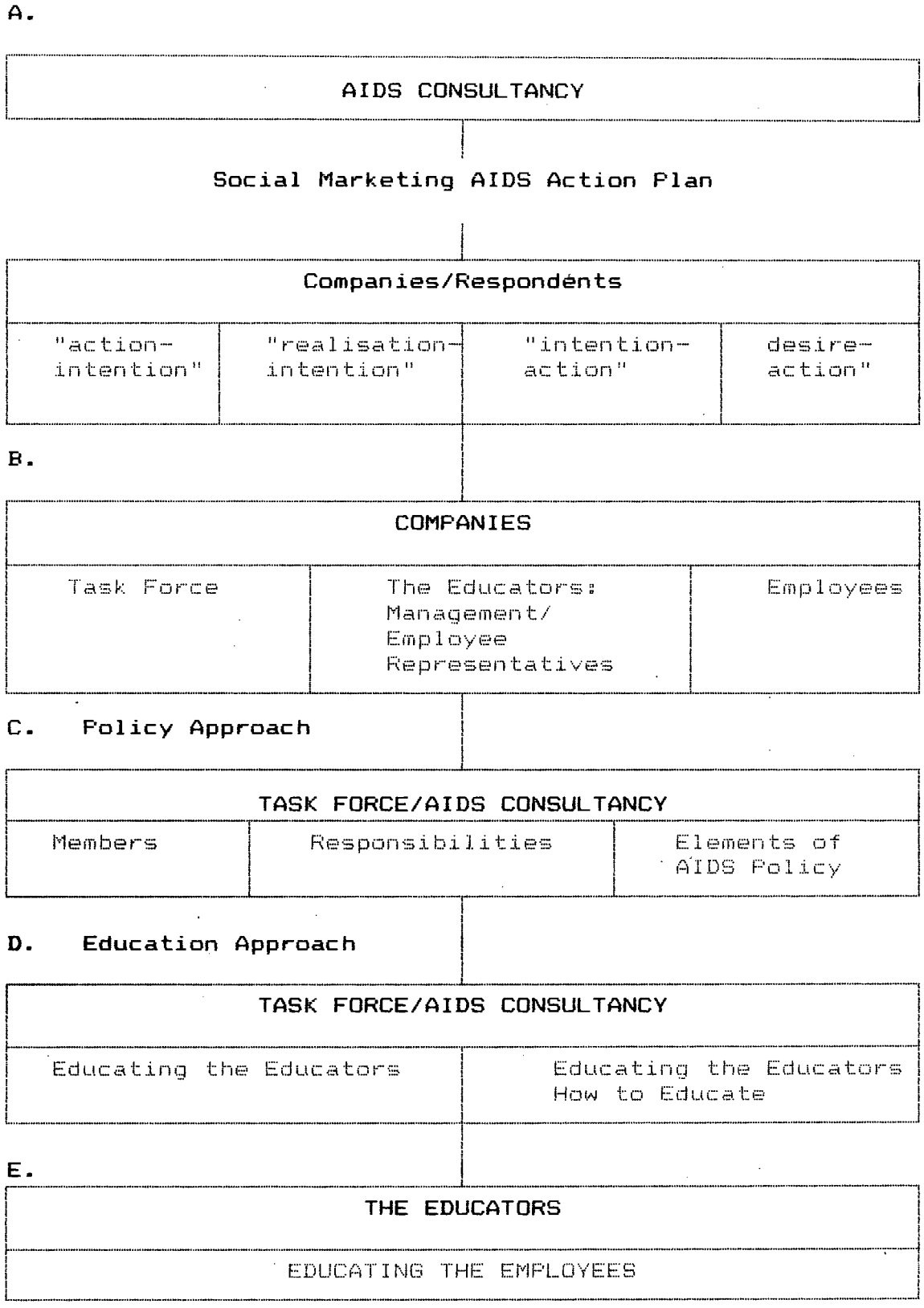


FIGURE 23: Social Marketing Workplace AIDS Action Plan

Figure 23 describes the Social Marketing Workplace AIDS Action Plan.

There are five parts (A - E), all of which are interlinked. Each part is a "social marketing process" in itself.

Summary of the AIDS Action Plan

Part A: The AIDS Consultancy is the channel for delivering the Social Marketing AIDS "Action Plan" to the companies the target segment identified.

Part B: On the basis of the research findings, three target segments within each company have been identified: The Task Force, The Educators, The Employee Body. These target markets are central to the implementation of the "action plan".

Part C: The Task Force (in conjunction with the AIDS consultancy) is concerned with the development of the AIDS policy approach.

Part D: The Task Force (in conjunction with the AIDS consultancy) is concerned with educating the Educators.

Part E: The Educators are responsible for implementing the AIDS policy, and educating employees about the company's AIDS policy approach as well as general preventative AIDS education.

All the components of Figure 23 create a **synergistic, integrated whole.** Continuous communication and feedback between all the components is critical to the effectiveness of the social marketing process.

Each of the above "parts" shall now be explained in detail.

9.3.3 The Development of Social Marketing Guidelines to a Workplace AIDS Action Plan

This "action plan" is made up of two parts which are inextricably linked:

(1) Guidelines to a comprehensive AIDS policy, which is the foundation of and precursor to

(2) Guidelines to a preventative AIDS education programme.

The proposed approach has evolved from:

1. **Empirical research: what South African companies are doing, how they have gone about it, and what the respondents consider practical to implement in their workplace.**

2. A review of the relevant literature on social marketing and health issues

3. An examination of existing AIDS prevention programmes, especially workplace related projects, worldwide and locally

4. In-depth interviews with "AIDS prevention experts" and with management currently experiencing the challenges which AIDS in the workplace presents.

The following discussion involves:

Phase 1: The AIDS Consultancy and the Target Markets

Phase 2: The Target Markets Within the Companies

The Action Plan: Guidelines to a Comprehensive AIDS Policy

9.3.4 Phase 1: The AIDS Consultancy and the Target Markets

(**Part A** in Figure 23)

> 'At the core of any social marketing campaign are the individuals, groups, and populations who are intended to be the consumers of the campaign's products. They are called target adopters because they are the specific people whose acceptance and adoption of a social product will fulfil the objectives of the campaign.' (Kotler and Roberto: 1989)

Based on the research findings and discussions (chapter 6 - 6.17), the following primary **target markets** emerge:

(1) The respondents from companies which have realised the potential threat of AIDS, but have taken no action to minimise it.
(2) The respondents from companies which are intending to develop an AIDS policy and education programme shortly.
(3) The companies which are still in the process of formulating an AIDS policy/have informal AIDS policies/once-off AIDS education.

The secondary target market comprises those companies which have a formal AIDS policy and ongoing education.

The "action plan" should be adapted to suit the needs of each segment.

a. Shared Features of the Target Segments

- The majority of the respondents from the companies consider it practical to have a formal AIDS policy and undertake preventative AIDS education in the workplace. (7.2(a))

- These respondents demonstrate a commitment to AIDS prevention and are willing to further their efforts in this sphere.(6.15)

The respondents from the companies therefore recognise the need for action against the potential AIDS problem. This is highly significant as many **social marketing** campaigns fail because the target groups 'do not perceive a problem, want or need'. (Kotler and Roberto: 1989:30) It is now critical to get the companies to see this **"Social Marketing AIDS Action Plan"** as the solution to their problem

> '...the degree of **product-market fit** determines the value to the target adopters of what the social marketer is offering. Therefore, the fit affects the perception, attitude, and motivation of the target-adopter group. The wrong fit results in an inadequate or contrary response by target adopters.' (Kotler and Roberto: 1989:29)

The research findings and discussions (chapters 6 and 7) have provided the foundation for achieving a **product-market fit.** A means for **tailoring** the "action plan" to each company's/respondent's needs is required.

b. The Role of an "AIDS Consultancy"

The research findings (7.2(c)) show that an "AIDS in the Workplace" consultancy, making companies more aware of the potential implications of AIDS and the Workplace, and assisting them with their preventative AIDS measures, is considered practical by the majority of respondents from the companies.

> 'Distribution channels ... are the outlets for making social products available.' (Kotler and Roberto: 1989: 161)

It is recommended that an "AIDS Consultancy" is established in order to guide companies with the adoption of an AIDS policy and a preventative AIDS education programme. This AIDS consultancy would be the change agent, a **social marketing distribution channel** for delivering the action plan. This

consultancy should be "non-profit" in order to facilitate the adoption process, the higher the price, the higher the costs of adoption. It is critical that the monetary and non-monetary costs of adopting the action plan are kept to a minimum.

> '(Social marketing) adoption costs are either of a monetary or a non-monetary kind... The higher the price charged, the greater the adopters' costs of adoption and the fewer the target adopters. Therefore, social change campaigns must carefully price their products...' (Kotler and Roberto: 1989:174)

9.3.5 Phase 2: The Target Markets Within the Companies

(**Part B** in Figure 23)

> 'Different segments will have different needs and require specific marketing efforts.' (Kotler and Roberto: 1989:278)

Based on the research findings and discussions (chapter 7), the following primary **target markets within each workplace** have been identified:

a) The Task Force

b) Selected Management (and Elected Employee Representatives)

c) The Employee Body

> Social marketing requires knowledge of each target-adopter group' (Kotler and Roberto: 1989:271))

The following discussion explains: The reasons for targeting each segment, "unique characteristics" of each segment, and the status of each segment in relation to the "action plan".

(a) The Task Force

(i) Reasons for Targeting Segment 1: The Task Force:

- The majority of the respondents from the companies consider the development of an AIDS policy by a multidisciplinary task force to be practical (7.2(a))

(ii) "Unique Characteristics" of this target segment include:

They should be responsible for:

- understanding everything about AIDS and related Workplace issues (financial, legal, industrial relations...)
- formulating a company-specific AIDS policy
- communicating, updating and evaluating the AIDS policy: "the steering-committee"
- planning what the AIDS education programme will involve

(iii) Status of the task force relative to the "AIDS Action Plan":

The findings have shown that the majority of the respondents consider the undertaking of preventative AIDS provisions, to be practical to implement. Therefore, as long as the members of the task force are carefully chosen (on the basis of their expertise and potential contribution to the programme), the overall attitude should be favourable.

Therefore, rather than "convincing" them to adopt the "action plan", an adapted action plan, tailored according to each company's needs, must be developed.

b. Selected Management (and Elected Employee Representatives):

(The recommendations are based on the findings of the research. Since the respondents were not employee representatives, "and elected employee representatives" has been bracketed.)

(i) Reasons for targeting segment 2: Selected Management (and Elected Employee Representatives):

- The majority of the respondents from the companies consider educating management and employee representatives about AIDS-related Workplace issues to be practical. (7.3(a))
- The majority of the respondents consider the training of "Workplace AIDS Educators" to be practical. (7.3(a))

(ii) "Unique Characteristics" of this target segment:

- As leaders in the organisation, they have a duty to be well-informed and take an active role regarding AIDS employment issues
- They need to be the first to react to situations and therefore should be trained to communicate and implement the AIDS policy

(iii) Status of Management (& Employee Representatives) Relative to the "Action Plan":

This is largely company-specific, and it is the responsibility of the task force to ensure that management (and employee representatives) react to HIV-related situations in accordance with the company philosophy/policy.

Potential obstacles to co-operation include:

Management

- There may be **denial** - that AIDS cannot affect them as it only affects "others"
- AIDS may be considered to be a **punishment** for immoral behaviour.
- The belief that there should be no HIV-positive employees in the workplace: **discrimination.**

- **Rejection of open discussion** of sexually-related topics.
- The belief that **education** causes unnecessary **fear.**

Therefore, personal beliefs may conflict with the company's stance regarding AIDS. If the company has adopted a non-discriminatory, fair approach, (in line with WHO recommendations), even if personal discriminatory feelings cannot be overcome through education, management must be instructed that it is their duty to uphold and implement the company policy. If, however, the company adopts a discriminatory approach, unsupportive management may be the least of their problems (Industrial Relations incidents, legal action...).

Employee Representatives

In addition to the above, the following obstacles may exist.

- An **uneasy relationship** between management and employee representatives - no mutual trust
- **Rejection** of certain aspects of the company's AIDS policy
- **Suspicion** of the company's sudden concern over AIDS - when other, most obvious health issues in the workplace such as unsafe machinery, dust or noise have been ignored.
- **Different cultures**, languages, values and needs.

It is the responsibility of the task force to try and minimise the conflict and urge all parties to set aside their differences in order to unite against the potential devastating effect of AIDS on the workplace. Co-operation and compromise are the key.

c. The Employee Body

(i) Reasons for targeting segment 3: The Employee Body

- Undertaking preventative AIDS education in the workplace and the development of a network of employees educated about AIDS is considered practical by the majority of the respondents. (7.3(a))

(ii) "Unique Characteristics" of Segment 3

The employees should be:

- educated about the **company's stance regarding AIDS**, their rights, the employer's rights, legal issues...
- educated about **AIDS prevention in general** (preventative AIDS behaviour) in order to help curb its spread

(iii) Status of the Employee Body Relative to the "Action Plan":

The status of the employees relative to the package will vary from person to person, company to company. It is therefore critical to have well-trained educators educating the employees.

Two important "linking" factors which arise from this segmentation are:

1. Preventative AIDS education is equally important for the task force, management and employee representatives, and the employee body.
2. The process is hierarchical to the extent that the development of the preventative AIDS provisions and its success, depends on the level of commitment and involvement firstly, at the task force level, secondly, the management/employee representative level and thirdly the employee level. However, feedback from the "bottom-up", has a critical part to play in the achievement of the goals and objectives of the social marketing preventative AIDS action plan.

9.3.6 The Action Plan: Guidelines to a Comprehensive AIDS Policy:

(Part C in Figure 23)

a. The Task Force

The first step is to elect those responsible for the policy formulation: The implications of HIV/AIDS and the best policy approach should be a matter for consultation with all spheres of the workforce. Within each company, a selected, influential group (the task force) should be identified.

The question for the task force is not whether AIDS is going to affect their company, but to what extent and what precautions they can take. They should realise that AIDS is an area which is constantly changing: AIDS is a long term problem requiring a long-term, but flexible strategy.

(i) Members of the Task Force

This task force should include, where possible, a representative from each of the following spheres of the organisation: Top management, personnel/human resources, unions/employee representatives and occupational health/medical people. Since AIDS-related workplace issues impact on legal, employee benefits and industrial relations, input from these spheres would be valuable. (7.2(a)). The task force should decide who is to have responsibility for the various policy issues.

> '... social marketers are advised to recognise the situations that call for specific styles of leadership and choose one that is appropriate.' (Kotler and Roberto: 1989:334)

Examples of input and areas of responsibility include:

Personnel/Human Resources: problem resolution, gain top management support, selection policies, counselling services, must ensure proper education, identify community experts on AIDS for education/guidance

Senior Management: endorsement, commitment and involvement. Financial planning and assistance with respect to Preventative AIDS Efforts in the Workplace.

Unions: representing the employee body, participation in the formulation of the company policy, education and action plans, protection of employee rights, credibility with the employee body. In the South African industrial relations environment unions are essential partners. AIDS calls for joint management-union problem-solving.

Medical/Occupational Health: education, counselling, safe work practices. Where the company has a medical department, its key role in developing and continuing the AIDS education should be a specific part of the company policy. Analyse workplace risks, workplace safety concerns. Ensure that the correct medical terminology is used - for example HIV and AIDS.

Industrial Relations: co-operation with unions, employee relations. Especially in the SA labour environment, the company AIDS policy should be in compliance with any applicable collective bargaining agreement.

Legal: protection against unfair labour practice, avoiding legal exposure.

The presence of employee representatives elected by all the employees is especially critical for two reasons: Firstly, they understand the needs of the employee body and thus, where necessary can defend their rights. Secondly, their participation in the formulation and implementation of the AIDS policy will serve to enhance the acceptance and credibility of the policy in the eyes of the employees.

The activities of all the members of the task force should be co-ordinated to ensure an integrated approach. It is therefore critical to assign a task force co-ordinator whose responsibility it is to co-ordinate the various representatives resources and inputs, in order to achieve a synergy. The task force co-ordinator should ensure: the smooth running of the policy and education, that actions and messages consistent with the company philosophy are being transmitted, and, generally communicate with all the different spheres and act as a central, unifying force.

> 'Social marketers do their work by continually assessing, planning, implementing, controlling, evaluating, and replanning their programs' (Kotler and Roberto: 1989: 322)

The approach should be flexible. It should be reviewed and updated in the light of new information which becomes available. Continued consultation between all the relevant groups is essential.

> 'The final consideration in designing a social product involves conveying an acceptable image of the social campaign behind the product, its staff, mission, and competence and value of its goals. When a product or a message communicating a product arises from a campaign or campaign staff that enjoys credibility and respect, the likelihood that the product will be adopted is greatly increased.' (Kotler and Roberto: 1989: 154)

(ii) Responsibilities of the Task Force: The "10 C's"

(1) **Committed:** The task force must be committed to the development and implementation of the policy.

(2) **Concentrated:** Owing to the need to act now (urgency), the efforts must be concentrated as opposed to drawn out.

(3) **Co-ordinated:** The co-ordination of all the members' resources and inputs is vital in order to achieve synergy.

(4) **Consistent:** Consistency, in terms of the elements of the AIDS policy as well as how it fits into the whole profile of the organisation is critical.

(5) **Compromise:** The members of the task force (representatives of the different spheres which may have conflicting goals), must be prepared to compromise.

(6) **Credibility:** A primary aim should be the credibility of the policy in the eyes of the employees. The above should ensure this.

(7) **Communication:** The policy must be communicated clearly through suitable, open channels of communication. Feedback should be encouraged.

(8) **Confidence:** The overall confidence of all the organisation's members should be gained in order to enhance the effectiveness of the policy.

(9) **Concern:** The policy should send a corporate social responsibility message to employees, customers and the community emphasising its concern for the well-being of society.

(10) **Continuous:** The policy should be continuously updated, reviewed and refined in the light of new trends and discoveries.

(iii) Elements of an AIDS Policy which should be considered by the Task Force:

- Purpose and Philosophy

The AIDS Policy should begin with the purpose and philosophy of the policy. This is important as it clearly states the overall attitude of the company. For example:

> To ensure both the well-being of the company and the employees (as well as the community at large) by attempting to maximise stability and productivity while minimising fear, disruption and prejudice in the workplace by means of a non-discriminatory policy and a well-planned, comprehensive preventative AIDS education programme.

- **The Policy should be Formalised**

(7.2(a))

This is necessary as AIDS employment issues are highly sensitive and controversial. A formal, written document would serve to clarify the company's stance regarding AIDS. It would also serve to ensure that when the need arises, procedures are uniform, consistent, fair and in keeping with the philosophy of the policy.

The company may choose to adopt an AIDS specific policy or a general life-threatening disease policy.

- **Highlight the Medical Facts**

(7.3(b))

Since AIDS is a complex and unusual disease, the company AIDS policy should highlight the medical facts: the stages of the disease, how HIV is and is not transmitted, that HIV cannot be transmitted through casual contact in the workplace, and the difference between being HIV-positive and having AIDS should be stressed. The needs of customers, first aid staff, management, employee representatives and employees with and without HIV, should be addressed. The policy should offer guidelines on all aspects of the disease, the company's standpoint, and the rights and responsibilities of every member of the organisation.

- **Commitment to Education**

(7.3(a))

The policy should also cover a commitment to education as the most effective way of preventing the spread of AIDS.

- **Approach to AIDS Issues at Pre-employment and "During Employment"**

(7.2(a), 7.2(b))

The research findings show that the respondents do not all agree with respect to a pre-employment and "during employment" AIDS policy approach. This confirms that there is seldom a universally accepted approach where controversial issues are concerned. (Although the WHO recommendations regarding HIV-related employment issues are "universal" to the extent that they are intended for a variety of different industries and organisations, every company has its own philosophy and culture which shapes its policies and actions. The uncertainty and controversy which surrounds AIDS employment approaches prevents the adoption of "universal guidelines". (section 7.4.3)

Although the author's views correspond to World Health Organisation and International Labour Organisation recommendations (see appendix B), it is hard to prescribe what the companies should and should not be doing. Education regarding the AIDS policy issues is critical. Rather than prescribing what policies issues should be adopted, guidelines should be developed with the emphasis on facilitating well-informed, company specific decisions. The opinions and recommendations of recognised local and international bodies should be communicated.

Owing to the lack of concensus arising from the empirical study, the following issues need to be considered include:

- **HIV pre-employment screening?** (section 7.2(b))
- **The employment of an HIV-positive applicant?** (section 7.2(b))

- **Employees and routine HIV tests?** (section 7.2(c))
- **Gaining the consent of all those tested for the HIV virus?** (section 7.2(b))
- **The counselling of all applicants/employees tested for the HIV virus?** (section 7.2(b))
- **Continued employment of an HIV-positive employee?** (section 7.2(c))
- **An AIDS policy stating that an HIV-positive employee will be treated no differently to any other employee?** (section 7.2(c))
- **Not reassigning all HIV-positive employees to duties which eliminate the need for human interaction?** (section 7.2(c))
- **Disciplinary action against co-workers who, (after AIDS education sessions), refuse to work with an HIV-positive employee?** (section 7.2(c))

The majority of the respondents consider the following to be practical to implement in their companies:

- **Maintaining the confidentiality of an HIV-positive employee.** (section 7.2(c))
- **The establishment of an active safety committee comprising of management and employee representatives.** (section 7.2(c))

All the above issues have been discussed. (chapter 7)

It is the responsibility of the AIDS Consultancy to develop an AIDS "action plan" in conjunction with the task force. The role of the Consultancy is not as "impartial" as it appears. This is an "Internal Social Marketing Action Plan". It therefore strives to achieve "external social marketing" - serving the goals of society.

> 'The only responsible answers to the AIDS epidemic lie in prevention, education and **non-discrimination.** Non-discrimination is not only the humane and compassionate response. It is also the most sensible. Employers ... bear a social responsibility to refrain from irrational conduct and to fulfil their public obligations in regard to the crisis.' (Cameron: 1991)

The emphasis of the AIDS Consultancy should therefore be to facilitate well-informed, **non-discriminatory** company-specific decisions. The ultimate choice lies with the task force. The potential for a company to adopt a non-discriminatory "during employment" policy approach is greater than the adoption of a non-discriminatory "pre-employment" policy approach. This is as a result of the legislative measures which exist to protect the rights of employees. (The opinions of legal experts in South Africa have been discussed in chapters 4, 6 and 7.)

Where possible, the AIDS Consultancy is dealing with a multidisciplinary task force. This can prevent a unilateral decision by a select group with common interests: The members of the task force represent different spheres of the workforce with diverse interests. For example, a member of the task force may suggest excluding all HIV-positive applicants owing to their potential detrimental affect on all areas of the workplace. Such a view may be opposed by other members of the task force who believe that if the company is prepared in terms of policy and education, workplace disruption need not occur... A multidisciplinary task force therefore affords the AIDS Consultancy an opportunity to debate the various issues with individuals representing different areas of interest within the organisation.

A discussion on the issues which the AIDS Consultancy should highlight when dealing with some of these contentious issues follows:

Example: HIV Pre-employment Screening?

As discussed in section 7.2(b), this is a highly controversial issue. The AIDS consultancy should ensure that each company arrives at a well-informed (**non-discriminatory**) final decision. The contentious issues should be debated. The task force should then be in a position to select the most suitable.

For example:

The Consultancy should acknowledge the arguments for testing which include:

- It fits into existing employment practices: A company may presently require medical examinations, and therefore may see HIV testing as consistent with this policy.
- A company expects employees to spend a certain length of time in their employment, and may invest in them by training them. An HIV-positive employee may not fulfil this expectation.
- Having employees with HIV may create industrial relations problems, legal problems and occupational hazards.

The consultancy should then **counter these views** with the following:

- Pre-employment testing makes recruitment more expensive and delays making appointments. (pre- and post-test counselling is necessary)
- It takes many "productive years" to develop AIDS. By excluding people with HIV from the workplace, one is contributing to the creation of a pool of unemployable people.
- The only medical criterion for employing people should be the ability to perform the job.

- A company which is proactive and prepares for the potential impact of AIDS on its workplace should not experience the problems associated with employing HIV-positive employees. (industrial relations, legal, workplace disruption...)
- It contradicts the efforts by the company to reassure existing employees concerning safety and infection in the workplace: Education about how AIDS cannot be spread in the workplace is not consistent with the exclusion of people with HIV from the workplace.

International and local opinion which reject pre-employment screening should be stressed.

Finally, after the issues have been thoroughly discussed, the task force should be in a position to arrive at a decision most suited to their particular workplace situation.

Example: An AIDS Policy Stating that an HIV-positive Employee will be Treated No Differently to Any Other Employee?

The above statement may be influenced by the medical aid rules: For example: a medical aid may have a limit of R100 per month for expenses arising from AIDS related illnesses. Although the whole issue of benefits currently remains unresolved, the task force in conjunction with the AIDS Consultancy should try to negotiate a company-specific AIDS-related benefits policy. (7.2(b))

Example: Employees and Routine HIV Tests

The consultancy may, for example, choose to highlight the Guidelines of the SA Society of Occupational Medicine regarding the testing of current employees: Testing is acceptable if:

- it is voluntary
- informed consent is obtained prior to testing
- confidentiality of test results is assured

- high quality laboratory services are utilised
- confirmatory testing is performed if the screening test is positive
- individuals are informed of the results
- employees are referred to counselling where appropriate

Example: The Establishment of an Active Safety Committee comprising of Management and Employee Representatives.

The AIDS consultancy should highlight that the responsibilities of this committee include:

- Ensuring that the company's approach to AIDS is consistent with their general policies on health and safety. (Workers often face many health and safety hazards: asbestos, hazardous chemicals, stress and infectious diseases are common concerns. The company's attitude towards these issues should be in line with their approach towards HIV.) It may be advantageous to incorporate preventative AIDS efforts within a wider programme for health and safety.
- Health and safety practices should be reviewed in order to ensure that there is no risk of exposure to blood and body fluids in the workplace.

Workplace Strategies include:

- Reviewing the infection control plan of the company
- Identifying any risk areas - Consultation with employees is critical as they know the problems at their own worksites.
- Investigating and acting on employee concerns
- Enforcing Occupational and Health and Safety Codes
- Providing ongoing education, training and counselling on HIV to health care workers: the facts, the potential risks, infection control, management and control of fear, educating and counselling skills

The Social Marketing Guidelines to an AIDS Action Plan in the Workplace which have been discussed, provide a framework for the task force to work within. **The outcome should be an AIDS policy approach tailored according to each workplace situation.** This policy approach should be dynamic and operative: **An Action Plan for the Management of the AIDS Challenge in the Workplace.**

The **AIDS Policy Approach** is the first pillar of the Social Marketing AIDS Action Plan.

The **Education Guidelines** which follow constitute the second pillar of the Social Marketing AIDS Action Plan.

9.3.6 The Action Plan: Guidelines to a Comprehensive AIDS Education Programme:

A Workplace Preventative AIDS Education programme is vital. (This is supported worldwide and by the respondents' responses in section 7.3(a) and 7.3(b).) The consequences within the workplace of being misinformed about AIDS can be detrimental to both employers and employees. For example: An ill-informed workforce may result in the spread of fear and discrimination, industrial relations and legal problems, workplace disruption, loss of productivity, etc. Failure to deal preventatively with the AIDS-related workplace issues, can only have adverse effects on the company concerned.

Therefore, the overall objective of the Social Marketing Workplace AIDS Education Action Plan is to educate the entire employee body. Central to this is the education of **management** and **employees**. (The findings show that management and employee AIDS education (section 7.3(b)) should be managed separately - the AIDS education should be tailored according to each audience.)

The design of the education programme will be influenced and constrained by a number of factors, including cost. The AIDS Consultancy should emphasise that the ultimate savings which emerge from an "AIDS educated employee body", will more than compensate for the expense of the programme. An AIDS education programme is an investment, and provides a return: Employee training assists employees in avoiding infection, and in responding appropriately to others in a work situation involving HIV/AIDS.

The AIDS education guidelines are based on the research findings in sections 6.5 and 7.3. As with the policy issues, the education programme should, where possible, be based on active collaboration between all spheres of the company, and where necessary, external organisations too.

Outline of the AIDS Education Guidelines

In order to achieve an educated **employee** body, the **dual nature of the employee AIDS education** must be understood: (The findings show that the majority of the respondents consider both types of education practical to implement in their workplace - section 7.3(c) - for example, educating about the company's AIDS policy and about adopting "safer sex".)

- **Education regarding AIDS-related Workplace issues.**

  The broad aim of this programme would be to:

  - minimise fear and anxiety concerning HIV/AIDS
  - inform employees about the company provisions for AIDS - their rights, as well as the rights of the employer.

- **Education regarding general preventative AIDS behaviour.** Since the workplace is part of society, it is important to utilise it for HIV/AIDS health education.

  The broad aim of this programme would be to:

  - help prevent the spread of HIV infection by educating how to adopt preventative AIDS behaviour
  - promote a sensitive, non-discriminatory attitude towards HIV-positive people, by addressing specific concerns/problems

  In order to satisfy these AIDS education requirements, which are inextricably linked, the research findings (section 7.3(a)), show that **the expertise of different educators is required.**

The Educators

> 'Once a social product is planned and designed, the critical issue is how to distribute and deliver the product to target adopters... The delivery of the social product usually depends heavily on interpersonal communications at the points of delivery.' (Kotler and Roberto: 1989:173)

The educators are integral to the social marketing AIDS educational programme aimed at employees. The educators form the all-important "**channel**" component of the social marketing mix - "middlemen". In other words, instead of building new "distribution channels", the current resources of the organisation are being exploited as "retailers" of the social marketing "action plan". (The "manufacturer" being the task force in conjunction with the AIDS consultancy.) Owing to the pivotal part which these "middlemen" play, their "recruitment" and education (phase 1), motivation, training and actions (phase 2), should be carefully planned, coordinated and controlled by the multidisciplinary task force.

- **Selected management (and majority elected employee representatives)** should be responsible for educating employees **regarding AIDS-related Workplace issues:** The companies stance with respect to an HIV-positive employee, the duty of the employer, the duty of the employees, legal issues...

  These educators have a valuable input to offer the preventative AIDS education programme. (Management has planning, organising, leading and controlling skills. The employee representatives can represent the employees, and identify with the cultures, values and needs of the employee body, thereby enhancing the education programme's credibility.) The education task should be handled cooperatively. Management and unions must work together. A management only campaign will not be trusted.

- **Counsellors (internal health care staff/external family planning clinic staff)** should be involved in the **general preventative AIDS education:** How to adopt safer sex practices, medical facts, counselling...

This dissertation recognises the pivotal role which counsellors have in the preventative AIDS education process. However, it does not include what form of counselling sessions would be most effective in achieving behaviour change, as this falls outside the domain of this study. The guidelines which follow are relevant to the counsellors, but are specifically designed for the "AIDS-related Workplace Issues Educators". Furthermore, since the research respondents were not employee representatives, the recommendations which follow are not specifically geared towards them. However, the central role which employee representatives have in the AIDS Workplace education is recognised, and much of the guidelines which follow should be applicable to them too.

A detailed discussion of the AIDS Education Outline follows.

This encompasses:

a. Phase 1: Educating the Educators
b. Phase 2: Educating the Educators How to Educate
c. Phase 3: Educating the Employees

a. Phase 1: Educating the Educators

(**Part D** in Figure 23)

> 'Social marketers must determine what product positioning is most suitable for each target-adopter segment... Two tasks are involved: to **identify the major needs** of the target-adopter segment and to **develop a product advantage to satisfy these needs.** Both must be determined for the product to be distinctive and motivating.' (Kotler and Roberto: 1989:151)

Major Needs of Management

Positive and competent programme leadership is critical. **Management require training on AIDS and related workplace issues.** They are implementing the AIDS policies, and therefore need special consideration and support. In addition to knowing what all employees should know about the HIV virus and its implications, management should be totally conversant with the company's policy on AIDS. The success of efforts to educate employees requires that the educators lend credibility by demonstrating support for the programme and by setting a strong personal example. Therefore the education of management should be preventative and reactive, since the actions of managers presented with an outbreak of rumour or a case of an HIV positive employee, may determine whether or not the matter becomes a costly disaster.

AIDS-related **Workplace issues** encompass general AIDS education. (For example, the fact that AIDS cannot be transmitted through casual contact in the workplace, has both medical and policy implications: Medically - AIDS can only be transmitted through contact with infected blood, from a mother to her child, through unprotected sexual intercourse. With respect to policy, this has implications in terms of continued employment of an HIV-positive employee, action against co-workers who demand that the employee be transferred to an isolated area...) It is therefore critical that there are open channels of communication between management, employee representatives and the AIDS counsellors, as their areas of instruction overlap. In fact, the nature of the AIDS challenge demands that management and employee representatives are well versed in general AIDS education, while the counsellors are familiar with the company's AIDS policy, the rights of the employer and employee.

These educators should be educated by the task force regarding the company's stance on AIDS-related Workplace issues. The counsellors have a dual responsibility of not only assisting the employee body, but ensuring that management are familiar with basic skills which traditionally they may have considered to be out of their domain. For example, basic counselling skills, medical facts surrounding AIDS...

How to Satisfy Management's Needs

Social marketers can take advantage of the attributes of **personal communication.**

> 'It is highly influential because of three distinctive characteristics: (Kotler and Roberto: 1989:222)
>
> 1. Personal communication entails numerous, diverse, and continuous interactions between the communicator and the recipient, or the target adopter...
>
> 2. Because of the interactive nature of personal communication, the personal communicator has the opportunity to initiate, build, and maintain a full range of relationships with the target adopter...
>
> 3. As interactions increase and intensify, the target adopter's sense of obligation to "return the favour" grows and brings him or her closer to adopting the social product.'

Despite this usually being a costly promotional communication tool, the structure of an organisation is more suited to personal communication than to mass communication.

> 'An education strategy is called for when the communicator deals directly with a group of people... The choice of the educational forum is based on what social marketers are capable of organising and what the budget will allow. The nature of the campaign agenda and the needs of the target adopters are also major factors.' (Kotler and Roberto: 1989:224)

By means of personal communication, the task force should ensure that management:

- are presented with **the facts.** (section 7.3(b)) This includes the following areas: medical, financial, economic, legal, industrial relations, ethical, social, political and religious. Comprehensive information is vital.
- are completely familiar with all spheres of the company **AIDS policy:** the philosophy of the policy as well as how to implement it (section 7.3(b))
- have **regular meetings** where they are informed of the latest AIDS-related developments, both internally and externally, and feedback on the preventative AIDS education, and company situation is given. To maintain credibility and trust, a major priority must be to have the most current, accurate information. (For example: legal issues - confidentiality, testing...)
- are aware of where further **knowledge regarding AIDS prevention** can be gained with minimum effort (for example, the availability of the company doctor/nurse/health services/task force for advice at convenient hours, a list of community resources for AIDS information). (section 7.3(b))
- are familiar with the **occupational health procedures** in the event of a workplace accident (In the majority of occupational settings, there is no risk of transmitting or acquiring HIV.) (section 7.2(b))
- realise that they are an important **link** in the battle against AIDS and its impact on the workplace.
- are motivated not only to educate about AIDS-related Workplace issues, but to set a **personal example** themselves.
- informed of all the above in a manner that is: **tailored according to** their needs, attitudes, values, cultures, education and socio-economic levels (section 7.3(b)), communicated through a **multichannel communication network** (posters/pamphlets, videos, guest speakers, newsletters, small group discussions ...), non-judgemental, relevant, sensitive and scientifically based. (sections 6.5 and 7.3(b))

Once management have been educated, they should be familiar with, understand and adhere to the company AIDS policy, be well versed in the medical aspects of AIDS, the myths and the support facilities offered by the company. Furthermore, they should now understand that decisions based on panic and emotional responses, are the result of not having a set of guidelines. They should now acknowledge that a proactive approach is the only approach.

The next phase is to ensure that they have the skills required to educate the employee body:

b. Phase 2: Educating the Educators How to Educate

> 'The promotion and delivery of social products, with or without a tangible-product base, are heavily dependent on the quality of interpersonal communication, interaction and the service provided by all those who are working in a campaign. Personal communication is embedded in virtually every facet of the promotion and adoption of social products. (Kotler and Roberto: 1989:221)
>
> 'Social campaigns depend on the reliability and predictability of their channel members, just as much as do businesses.' Kotler and Roberto: 1989:164)

The task force should be responsible for organising the training session. Where possible, the members of the task force/consultancy most qualified in the field of training should conduct the sessions. The sessions should be interactive, participative and not too time consuming. (section 7.3(b)) (A small group may be preferable.) Where possible, there should be an even spread of management and employee representatives.

(i) Preventative Training and Counselling

Firstly, management (and employee representatives) should be trained how to **educate** the employees about AIDS-related Workplace issues. (The qualified trainer should utilise various training techniques during the education programme.)

Management should be made aware of the need to:

(7.3(b))

- acknowledge preconceived ideas and emotions
- counter fear and anxiety
- reduce and forestall panic and disruption
- avoid discrimination
- dampen prejudice
- tackle the education sensitively
- convey relevant, realistic, direct, non-judgemental and scientifically based messages
- think like the audience
- overcome denial
- create awareness
- identify opinion leaders and "early adopters".

'Personal communicators should start with those benefits that are most credible, ...features that are of direct benefit to target adopters' (Kotler and Roberto: 1989:228)

Issues to be highlighted include:

- Recognition and **reward for contributions** to the programme.
- Their **responsibility to themselves and the company** to further the preventative AIDS programme. Emphasis should be placed on the fact that by virtue of their position, they have a duty, a moral obligation to promote the well-being of the employee body. (Furthermore, the importance of the programme for the well-being of the individual, the company and society as a whole - a "crusade-like" atmosphere, should be stressed.)
- Since the educators all have a valuable input, through **teamwork**, a synergy can be achieved.
- The thorough and **committed company approach.** This should be achieved by revising salient aspects of the company policy and explaining the comprehensive "plan of action".

- The ultimate **aim of the educators:** The development of a network of informed and committed employees so as to avoid continued dependence on the "middlemen"' and to create a "self-supporting" preventative AIDS education environment. (A "ripple effect".)
- **Cooperation** and compromise are both mutually beneficial and urgent.

Management who have actively participated or those who are regarded as opinion leaders should be asked to present brief "Workplace AIDS Issue" education sessions to the participants. (The audience should be encouraged to ask questions and to offer suggestions.)

Those members of the task force/consultancy/company most qualified in the field of **counselling** should highlight the importance of referring employees to counselling, as well as basic counselling skills to management. For example, they should be informed that:

- Counselling is a **supportive** and **sustained** form of interpersonal exchange which is fundamental to the AIDS prevention programme.
- Lectures, posters, pamphlets and videos are not enough.
- Often the employees will have to give up routine activities and change their lifestyles in order to adopt AIDS prevention behaviour. Through counselling, the employees can question, share and come to terms with alternative behaviours. It can help them select specific behaviours suited to their lifestyles as well as provide support to these changes.
- Counselling facilitates the understanding of AIDS in a personal and tangible manner.
- It provides an opportunity for venting anger, frustration and overcoming fears.
- Depending on the circumstances, counselling may take place in small groups or individually.

In order to develop management's counselling skills, enable them to recognise their own strengths and weaknesses, and in order to increase their awareness of possible constraints, role-playing is suggested. (Experience an "educator - employee"' interface.)

(ii) Reactive Training

Reactive training involves training management how to respond to the incidence of HIV-positive employees and its possible consequences.

> 'Personal communicators may seek to frame their messages on the basis of their relationship to a target adopter, rather than on the interaction alone. They must move from "transaction marketing" with its focus on making the initial sale, to that of "relationship marketing", with its focus on building a supportive relationship with target adopters over time.' (Kotler and Roberto: 1989:230)

The preventative training can be seen as "transaction marketing", and reactive training where special considerations need to be taken into account, as "relationship marketing".

Reactive training may involve applying company policy with respect to: (Management acting in accordance with company policy should be assured of company support with respect to HIV-related incidents which may have repercussions.)

- the strict maintenance of **confidentiality**
- no victimisation or **discrimination**
- **continued employment** and job normality
- **relocation** only where necessary
- the **benefits** package
- **absenteeism** provisions
- the **co-ordination** of workplace and community referral and support networks (in terms of medical provisions and counselling/education for the employee and his/her family/close friends).

Management should be prepared to deal with

- employees with HIV
- fear of co-workers
- rumours/fears about AIDS
- transfer requests
- work stoppage
- customer fears about AIDS

At the conclusion of the training course, management should be able to: re-examine and evaluate their own attitudes towards AIDS in general, understand their role in the delivery of the AIDS education, identify up to date features of HIV/AIDS, identify problematic areas, develop a personalised training programme designed to suit their requirements, and utilise their newly acquired educative-counselling skills of disseminating information to the workforce.

A summary of the important aspects of the training session should be provided. (Perhaps this could be in the form of a hypothetical case study highlighting the "do's and don'ts".)

The establishment of a task force, formulation of an AIDS policy, and education of educators represents a company which is prepared for the AIDS challenge. Such a company is now ready to implement its AIDS policy and educate its employee body. The foundation for an AIDS-educated employee body: for minimising workplace disruption and curbing the spread of AIDS, has been laid.

c. Phase 3: Educating the Employees

(**Part E** in Figure 23)

> 'The satisfaction of target adopters is the outcome of two forces: the target adopters' needs and expectations and a social change campaign's performance. A campaign's performance, in turn, depends on the **quality of the social campaign's personnel...**' (Kotler: 1989:248)

The **education of the employee body is the responsibility of the educators.** Phase 1 and Phase 2 should have them well prepared for this task.

Purpose:

To provide factual information to the employee body about HIV/AIDS so that they can act in their own best interests. This includes how to avoid exposure to the disease, allaying fears about working with persons who are HIV positive, and examining all the Workplace issues which AIDS brings to the forefront.

Programme Options

There are different combinations of educational methods: (sections 6.5 and 7.3(b))

- It is critical that management choose the most appropriate method of communication.
- This choice depends on the ground to be covered, with whom they are communicating, expertise available, structured versus open discussion, amount of time, the specific learning objectives...

Different techniques include:

- Having a multichannel communication approach (videos, guest speakers, newsletters, posters, pamphlets, small and large group discussions ...) For example, an introductory session may involve having a video followed by a discussion and scenarios. This may be followed by the distribution of newsletters, posters and pamphlets. The next session may involve a set of true/false questions on AIDS-related Workplace Issues, role play...

Owing to the dual nature of the employee AIDS education programme, the aim is two-fold:

(i) Workplace AIDS Education

Management should aim to:

- **Tailor the education** according to the needs, attitudes, behaviours, values, cultures, perceptions and education levels of the employees. This involves: Understanding the culture of the audience, and anticipating the values which may dominate the learning environment; Determining and customising the focus, length and the content of the discussion to be presented, according to the specific audience. (section 7.3(b))

- Create a **supportive environment** where frank discussion can occur, and concerns related to AIDS in the workplace can be shared

- Present the basic **medical facts**, the myths and foster discussion about how to react to AIDS in the workplace and in general. Information that is closely tied to fact and scientific studies, should be presented in an objective and professional way. (section 7.3(b))

- Ensure that a majority elected **employee representative** is present, and actively contributes to the discussion.

- Carefully explain the **company AIDS policy** emphasising all aspects relevant to the employee body (section 7.3(b))

- Discuss any **AIDS-related risks** associated with certain situations, and where necessary, explain the precautions which should be taken (section 7.2(c))
- Highlight the importance of **rumour control**, and the consequences of misinformation.

- Provide information on **company facilities** regarding AIDS prevention. (For example, health services open at convenient hours, condom machines.) (section 7.3(b)))

- Distribute preventative AIDS education **pamphlets** (where necessary in different languages) to employees to take home to their families and friends ("ripple effect"). (section 7.3(b))

- Be linked to relevant external bodies and community services to create a support network (as well as learn from others' experiences).(section 7.3(b))

(ii) General Preventative AIDS Education

Counselling is an important component in the overall delivery of health care services: AIDS has long been recognised as a disease which requires more than just medical care. Emotional support is essential. **Counselling has two main aims: education** and **support.**

The counsellors should:

- communicate **information** in an accurate, consistent and objective manner, answer employee concerns and questions with respect to AIDS

- be able to keep abreast of the **rapid changes** taking place in the field of AIDS

- **understand** differences in **employee backgrounds,** culture, and life-styles, in order to establish a good counselling relationship.

- use their basic **counselling skills:** empathy, warmth, respect, non-judgemental attitude, in order to provide support to employees

- recognise when **referral** to external counselling/medical services is needed. For example, when professional experience is needed to manage common psychological and clinical complications arising from HIV infection: anxiety, depression, possible neurological indications.

- be aware of those **employees most in need** of counselling: HIV-positive employees, those who are worried about developing AIDS, those having the HIV antibody test - coping with a positive test result, first aid staff, family and friends of a person with HIV, co-workers who refuse to work with an employee with the virus, employees who will not tolerate anything to do with AIDS...
- **alleviate the fear and ignorance** surrounding AIDS and promote behaviour change to stop the spread of the disease.

- **provide motivation for partaking** in the programme and adopting preventative AIDS behaviour. For example, reinforcing the inherent human desire to remain healthy and minimising the amount of effort required to fulfil this desire.

- induce/assist the employees to **adopt AIDS prevention behaviour**

- **alter the deeply felt beliefs/values** that employees may have (for example against condoms)

- **reinforce** positive attitudes and behaviour

- **convert** positive attitudes into positive behaviour

- **transform** negative attitudes and behaviour into positive attitudes and behaviour.

Where possible, innovative techniques such as games, drama and storytelling, puppet shows and role play should be used.

Obstacles to effective AIDS education such as those discussed in section 9.3.5 (b) should be dealt with in special counselling sessions by the most qualified educator in that field.

Management and counsellors may choose to have separate or joint education sessions, depending on the particular workplace situation and audience. Regardless of which approach is used, it is critical that the messages transmitted are consistent, co-ordinated and complementary.

The "Workplace AIDS Education", and the "General AIDS Education" should develop into an ongoing programme (section 7.3(b)) which provides repeated exposure to preventative AIDS messages. The follow-up sessions and feedback from employees are particularly important as the "post-purchase" behaviour is even more crucial than the "adoption" of the AIDS programme.

> 'The final stage of managing a social marketing campaign involves evaluation. Two issues are foremost: (1) Has the campaign brought about the changes intended and have other factors led to change? (2) Has it brought about changes that are desirable from a societal and ethical point of view, employing the right means to achieve the desired ends.' (Kotler and Roberto: 1989:342)

Included in this programme should be a mechanism to monitor the progress of the "action plan", and to what extent the aims and objectives have been accomplished in the light of the above criteria. Feedback from management, employees and all those involved in the preventative AIDS education is critical to the success of the social marketing AIDS action plan.

The workplace is part of the broader society. AIDS impacts on all spheres of society. "Networking" between the "workplace" and external organisations and the community is essential:

The findings in chapter 6 show that many of the respondents do not exhibit an overall willingness to **assist** companies smaller than their own with preventative AIDS efforts, nor assist in community AIDS prevention programmes. (section 6.15) However, the findings in chapter 7 show that the majority of the respondents consider an AIDS education programme for management, employee representatives and employees, which is "**linked** to relevant external bodies and community services" **practical** to implement in their workplace. (section 7.3(b))

It therefore appears that many of the respondents are not willing to **assist** AIDS prevention efforts external to their workplace, **but** would like to be **linked** to such organisations/projects. The latter can perhaps be attributed to the desire to benefit from the expertise of others. This finding has both "positive" and "negative" implications: On the "positive" side, the respondents are willing to learn from others in order to improve their preventative AIDS education in the workplace. On the "negative" side, many of the respondents are not willing to reciprocate by providing assistance in the form of expertise or financial aid.

It is the responsibility of the AIDS Consultancy to impress upon the companies that AIDS in the workplace is a vital cog in the AIDS pandemic wheel. Corporate social responsibility regarding AIDS in the community is thus mutually beneficial to both the companies and communities concerned. Employers maintaining that their only concern is AIDS in the workplace, can detract from the effectiveness of an otherwise well-planned AIDS education programme. The corporate-community AIDS assistance programmes can vary across a wide spectrum of activities from supporting external organisations financially to independent campaigns.

The AIDS Consultancy in "delivering" the Guidelines to the Social Marketing AIDS Action Plan" should assist the companies in developing an "expertise-sharing" relationship with existing external bodies as well as between the companies themselves. Furthermore, although the "action plan" can be adapted to meet the requirements of smaller businesses, in the absence of existing human resources to make up the multidisciplinary task force, assistance should be provided.

Therefore, the workplace and community preventative AIDS education programmes should complement one another to form a strong supportive network. It is recommended that, instead of building new community AIDS education structures, the present health education infrastructure should be strengthened.

An example of organisations which are well placed to play a vital role in the fight against AIDS are "Family Planning Clinics". They provide a comprehensive service, the primary aim being to promote family health - not merely birth control. They distribute contraceptives, provide emotional support and education to help people gain more control over their sexual lives, as well as identifying and referring people with problems. As in the past, Family Planning Clinics once again need to act as catalysts for change.

The integration of AIDS into the Family Planning Programme also furthers the aims of the clinics: AIDS has made it possible to talk about sex more openly thereby facilitating the promotion of responsible sexual behaviour. Furthermore, the publicity surrounding AIDS creates greater access to the media and hence forges new links with the community, other health services and target groups.

Thus the companies should strive to create a mutually beneficial support and referral network between themselves and the community (particularly communities in which most of their employees reside).

9.4 Further Directions for Future Research

a. This dissertation should form the basis of further research into the preventative provisions which have been made for AIDS and its impact on the workplace among South African companies: Since the "AIDS in the Workplace" issue is still in its infancy and therefore characterised by much uncertainty, it would be worthwhile to conduct similar research in the near future. Such a study should provide further valuable insight into the preventative AIDS provisions which South African companies have undertaken.

b. This dissertation has suggested "Social Marketing Guidelines to an AIDS Action Plan". The research challenge would be to demonstrate that such an "action plan" can achieve its objectives.

c. This dissertation has suggested guiding principles to the management of "AIDS in the workplace". The respondents to the mail questionnaire were not union representatives. It would be valuable to conduct similar research from a union perspective, in the near future.

9.5 Concluding Remarks

This dissertation set out to investigate the provisions which have been made for AIDS in the workplace by the companies in the sample, and the preventative AIDS provisions which the respondents from the companies consider "practical" to implement in their workplace. Social Marketing Guidelines to a Workplace Preventative AIDS Action Plan have been suggested. The objectives and hypotheses as stated in chapter 1, and discussed in chapters 6 and 7, have facilitated the achievement of the overall research objective.

AIDS in the workplace epitomises the challenges and complexities of the disease. Instead of allowing the issues which "AIDS in the Workplace" brings to the forefront to become insoluble, these issues should be transformed into areas around which cooperation and negotiation exist. This research is the catalyst for overcoming the difficulties which the epidemic presents to the workplace. It compels a fresh look at the responsibility of business to both its employees and society. It brings the corporate sector to a crossroads, and points the way for committed collective action.

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SA Advisory Group on AIDS (1988)

APPENDIX A

UNIVERSITY OF CAPE TOWN

Department of Business Science

University of Cape Town · Private Bag · Rondebosch 7700
Telephone: 650-2311
Fax No.: (021) 650-3726

Dear

I am doing my Masters in Business Science at the University of Cape Town on "AIDS in the workplace".

By completing this questionnaire, you will be contributing substantially to the body of knowledge available on "AIDS in the workplace".

The results of this study, once made available, will be certain to offer a deep insight into current problems and policy solutions. Please answer every question as they have been designed to cover all aspects of the topic under study. No identification is required.

Your commitment and participation is extremely highly valued.

Yours Sincerely,

Tracey Pikholz

P.S. Please endeavour to return this questionnaire by
(See enclosed envelope - postage paid)

SECTION 1:

DEMOGRAPHICS:

1. Industry _____

2. Position of respondent _____

3. Number of employees _____

PLEASE TICK THE RELEVANT BOXES:

RECRUITMENT AND SELECTION:

4. When recruiting and selecting employees, which of the followin **medical requirements** do you have? **(can tick more than one)**

   . medical questionnaire for everyone on recruitment ☐

   . medical examination for everyone at pre-employment ☐

   . screening for life-threatening diseases for everyone ☐

   . HIV screening at pre-employment for everyone ☐

   . none of the above ☐

(If you have any form of HIV screening at pre-employment, pleas continue to **question 5**, otherwise please see **question 7**.)

5. What **form** does the **HIV screening** take? **(can tick more than one)**

   .Verbal/Written (eg Could you due to past diseases/blood transfusions or past social habits have contracted the HIV virus?) ☐

   ."Testing" (eg "ELISA"test) ☐

   .Test:(Westernblot) ☐

6. Is this screening **compulsory**?

   Yes ☐

   No ☐

7. Given the case of a suitable applicant with **any life-threatening disease excluding AIDS** (eg cancer), what is your company's policy for **recruitment**?

. no policy, but would usually turn away ☐

. no policy, depends on circumstances ☐

. no policy, but would not matter ☐

. policy to employ with no provisos ☐

. policy to employ but certain provisos (eg no medical aid.) ☐

. policy not to employ ☐

. unsure ☐

. other (please specify) _____

8. Given the case of a suitable applicant who is **HIV-positive**, what is your company's policy for **recruitment**?

. no policy, but would usually turn away ☐

. no policy, depends on circumstances ☐

. no policy, but would not matter ☐

. policy to employ with no provisos ☐

. policy to employ but certain provisos (eg no medical aid.) ☐

. policy not to employ ☐

. unsure ☐

.other (please specify) _____

AIDS AND CURRENT EMPLOYEES:

9. Do you **offer HIV testing** for present **employees**? (eg: in the workplace/refer to external body)

Yes ☐

No ☐

(If **yes**, please continue to **question 10**)
(If **no**, please see **question 12**)

AIDS AND CURRENT EMPLOYEES: (continued)

10. Is this test **compulsory**?

Yes ☐

No ☐

11. How often is this test **repeated**?

. not at all ☐

. half yearly ☐

. annually ☐

. on request ☐

. other (please specify) _____

12. What **actions** would you take with an **HIV-positive employee**? (ca **tick more than one**)

. nothing ☐

. unsure ☐

. dismiss ☐

. relocate ☐

. refer to professional guidance/counselling ☐

. other (please specify) _____

13a. If an employee is HIV-positive, is this (or would this be) kept **confidential**?

Yes ☐

No ☐

Unsure ☐

13b. If no, why not?

_____

_____

_____

THE EFFECT OF AIDS ON THE COMPANY:

14. In what manner do you think AIDS will **affect your company? (can tick more than one)**

a . no effect ☐

b . unsure ☐

c . decreased productivity (eg increased absenteeism/ shortage skilled manpower) ☐

d . disruption of the conduct of business ☐

e . bad for company image ☐

f . very costly ☐

g . legal implications (eg:unfair labour practice) ☐

h . other (please specify) _____

PLEASE RANK THE ABOVE IN ORDER OF IMPORTANCE:

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

15. How much **overall impact** do you think AIDS will have on your company?

NOW		**5 YEARS TIME**	
. none	☐	. none	☐
. some	☐	. some	☐
. a lot	☐	. a lot	☐
. unsure	☐	. unsure	☐

16. If an **employee were HIV-positive**, how do you think it would **affect the department** in which he/she works? (**can tick more than one**)

Co-workers know:

. hazardous due to possible injury (eg machinery) ☐

. harmful to relationships between employees (eg fear, rejection) ☐

. decreased performance of the HIV-positive employee ☐

. decreased performance of co-workers ☐

. no effect ☐

. other (please specify) _____

Co-workers do not know:

. hazardous due to possible injury (eg machinery) ☐

. decreased performance of the HIV-positive employee ☐

. no effect ☐

. other (please specify) _____

AIDS AND COMPANY POLICY:

17. What provision is made for AIDS in company policy?

. formal ☐

. informal ☐

. none at all ☐

(If **formal** or **informal**, please continue to **question 17.1**)
(If **"none at all"**, please see **question 22**)

17.1 Has/will any special provision be(en) made for the HIV-positiv employee in the **group benefit scheme**?

. Yes ☐

. No ☐

. Other (see question 18) (please specify) _____

18. How did you go about **formulating** this policy? (**can tick more than one**).

. a task force appointed ☐

. on advice from other bodies (eg ASSOCOM,IPM) ☐

. volunteers (eg knowledgeable employees) ☐

. independently ☐

. other (please specify) _____

19. Who was most **involved** in **formulating** this policy? (**can tick more than one**)

. top management ☐

. human resource/personnel department ☐

. industrial relations department ☐

. unions ☐

. external body ☐

. volunteers (eg knowledgeable employees) ☐

. other (please specify) _____

20. How is this policy **communicated** to **management**? (**can tick more than one**)

. part of formal policy ☐

. education (eg seminars/courses) ☐

. routine activities (meetings/newsletters) ☐

. in the process of formulating how to do so ☐

. other (please specify) _____

21. How is this policy **communicated** to **employees**? (**can tick more than one**)

. part of formal policy ☐

. education (eg seminars/courses) ☐

. through unions ☐

. management/supervisors ☐

. routine activities (meetings/newsletters) ☐

. in the process of formulating how to do so ☐

. other (please specify) _____

(**please see question 23**)

22. Why has **no provision** been made for **AIDS in company policy**?

- . unsure ☐
- . don't know how to go about it ☐
- . inadequate resources ☐
- . intending to make such provisions shortly ☐
- . in the process of making such provisions ☐
- . other (please specify) _____

AIDS AWARENESS:

23. How **aware** do you consider management and employees to be with respect to AIDS?

a. MANAGEMENT		b. EMPLOYEES	
. unaware	☐	. unaware	☐
. low awareness	☐	. low awareness	☐
. moderate awareness	☐	. moderate awareness	☐
. high awareness	☐	. high awareness	☐
. unsure	☐	. unsure	☐

PREVENTATIVE AIDS EDUCATION:

24. What **type** of preventative **AIDS education** does your company conduct amongst management and amongst employees?

a. MANAGEMENT		b. EMPLOYEES	
. none	☐	. none	☐
. ongoing workshops	☐	. ongoing workshops	☐
. once only workshops	☐	. once only workshops	☐
. only posters/pamphlets	☐	. only posters/pamphlets	☐
. other (please specify) _____		. other (please specify) _____	

(If **none or only posters/pamphlets**, please continue to **question 24c** - otherwise please see **question 25**)

PREVENTATIVE AIDS EDUCATION: (continued)

24c. Why is there **no** organised preventative **AIDS education** in your company?

. unsure ☐
. unnecessary ☐
. don't know how to go about it ☐
. inadequate resources ☐
. intending to do so shortly ☐
. other (please specify) _____

(please see **question 34**)

25. Do **internal staff** or **external** organisations deal with the preventative AIDS education?

. neither (see question 28) ☐
. both ☐
. external (see question 27) ☐
. internal ☐

26. How do **staff qualify** for becoming AIDS educators? (**can tick more than one**)

. by virtue of employment category (eg personnel dept) ☐
. workshops/conferences ☐
. medical/occupational health person ☐
. volunteers ☐
. other (please specify) _____

(If only **internal**, please see **question 28**)

27. Which **external organisations** have assisted your preventative AIDS education programme?

_____

_____

PREVENTATIVE AIDS EDUCATION: (continued)

28. What **form** does the **management AIDS education** take? (**can tick more than one**)

a. posters/ pamphlets ☐
b. meetings ☐
c. videos ☐
d. visiting "experts" ☐
e. workshops ☐
f. conferences ☐
g. guidance/counselling ☐
h. other (please specify) _____

PLEASE RANK THE ABOVE IN ORDER OF IMPORTANCE:

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

29. What **form** does the **employee AIDS education** take? (**can tick more than one**)

a. posters/ pamphlets ☐
b. meetings ☐
c. videos ☐
d. visiting "experts" ☐
e. workshops ☐
f. conferences ☐
g. guidance/counselling ☐
h. other (please specify) _____

PLEASE RANK THE ABOVE IN ORDER OF IMPORTANCE:

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

PREVENTATIVE AIDS EDUCATION:(continued)

30. What **effect** do you think the preventative **AIDS education** has or **management**? (**can tick more than one**)

. no effect ☐

. greater awareness of the potential impact of AIDS in the workplace ☐

. less promiscuity ☐

. more acceptance/tolerance of HIV-positive people ☐

. medical/factual understanding (less prejudice) ☐

. other (please specify) _____

31. What **effect** do you think the preventative **AIDS education** has on employees? (**can tick more than one**)

. no effect ☐

. greater awareness of safer sex ☐

. less promiscuity ☐

. more acceptance/tolerance of HIV-positive people ☐

. medical/factual understanding (less prejudice) ☐

. other (please specify) _____

32. Does the preventative **AIDS education** take any of the following into account? (**can tick more than one**)

. different cultural backgrounds ☐

. different socio-economic backgrounds ☐

. levels of education ☐

. different values ☐

. different needs/emotions (eg fear) ☐

. other (please specify) _____

. none of the above ☐

PREVENTATIVE AIDS EDUCATION: (continued)

33. Have **unions/employee representatives** been involved in the preventative AIDS education?

. Yes ☐

. No ☐

(If **no** please see **question 34**)

SCOPE FOR FURTHER AIDS EDUCATION:

34. Is the company **willing** to devote (additional) **resources** (eg finance, time) to preventative **AIDS efforts (education/activities)** in the workplace?

. Yes ☐

. No ☐

35. Is the company **willing** to provide **assistance** (with respect to preventative AIDS education in the workplace) to other **less resourceful companies** than themselves?

. Yes ☐

. No ☐

(If **yes**, please continue to **question 36**)

(If **no**, please see **question 37**)

36. What **form** would this **assistance** take? (**can tick more than one**)

. finance ☐

. sharing expertise (eg showing how to go about it) ☐

. other (please specify) _____

37. Does the company **assist** in **community AIDS** awareness/educatio campaigns?

. Yes ☐

. No ☐

(If **yes**, please continue to **question 38**)
(If **no**, please see **question 39**)

SCOPE FOR FURTHER AIDS EDUCATION: (continued)

38. What **form** does this take? (**can tick more than one**)

. supporting external bodies ☐

. independent campaigns ☐

. other (please specify) _____

39. If **no**, would the company **be prepared** to undertake preventative **AIDS education** in the **community** in the next year?

. Yes ☐

. No ☐

40. If **no**, **why** not? (**can tick more than one**)

. unnecessary ☐

. unsure why not ☐

. unsure how to go about it ☐

. inadequate resources ☐

. only concern is the workplace ☐

. priority to establish a strong programme within the workplace first and then only to proceed into the community (in not less than one year) ☐

. other (please specify) _____

SECTION 2:

Here are a number of statements which people have made about **"AIDS IN THE WORKPLACE"** issues.

How **PRACTICAL** would it be to **IMPLEMENT** the following in your workplace?

Answers should given on the following scale:

HIGHLY PRACTICAL	PRACTICAL	UNSURE	IMPRACTICAL	HIGHLY IMPRACTICAL
1	2	3	4	5

(PLEASE RING THE APPROPRIATE NUMBER)

(A) COMPANY AIDS POLICY

* The undertaking of preventative AIDS provisions (policy/education) before HIV-related issues arise in the workplace.
  1 2 3 4 5

* An AIDS policy stating that an HIV-positive employee will be treated no differently to any other employee.
  1 2 3 4 5

* A formal, written AIDS policy.
  1 2 3 4 5

* The development of an AIDS policy by a multi-disciplinary task force .
  1 2 3 4 5

(B) HIV-ANTIBODY TESTING:

* HIV-antibody pre-employment screening for everyone.
  1 2 3 4 5

* The counselling of all applicants/employees tested for the HIV virus.
  1 2 3 4 5

* The employment of an HIV-positive applicant.
  1 2 3 4 5

* Gaining the consent of all those being tested for the HIV-virus.
  1 2 3 4 5

* Persuading employees to have routine HIV-tests.
  1 2 3 4 5

* Maintaining the confidentiality of an HIV-positive employee.
  1 2 3 4 5

HIGHLY PRACTICAL	PRACTICAL	UNSURE	IMPRACTICAL	HIGHLY IMPRACTICAL
1	2	3	4	5

(C) **PREVENTATIVE AIDS EDUCATION:**

* Educating management about AIDS-related workplace issues.
  1 2 3 4 5

* The inclusion of small group discussions in the preventative AIDS education programme.
  1 2 3 4 5

* The development of a network of employees, educated about AIDS.
  1 2 3 4 5

* The training of "preventative AIDS educators" how to educate about AIDS-related workplace issues.
  1 2 3 4 5

* Educating employee representatives about AIDS-related workplace issues.
  1 2 3 4 5

* Undertaking preventative AIDS education in the workplace.
  1 2 3 4 5

(D) **GENERAL:**

* Not terminating the services of an HIV-positive employee.
  1 2 3 4 5

* Reassigning all HIV-positive employees to duties which eliminate the need for human interaction.
  1 2 3 4 5

* Disciplinary action against co-workers who, (after AIDS education sessions), refuse to work with an HIV-positive employee.
  1 2 3 4 5

* The establishment of an active safety committee comprising of management.
  1 2 3 4 5

* The establishment of an active safety committee comprising of management and employee representatives.
  1 2 3 4 5

HIGHLY PRACTICAL	PRACTICAL	UNSURE	IMPRACTICAL	HIGHLY IMPRACTICAL
1	2	3	4	5

* Increasing the awareness of trade unions about "AIDS in the workplace" issues.
  1 2 3 4 5

* Joint corporate-community AIDS programmes.
  1 2 3 4 5

* "Big business" assisting "small business" with their preventative AIDS programmes.
  1 2 3 4 5

* Family Planning clinics having a role to play in preventative AIDS education.
  1 2 3 4 5

* An "AIDS in the workplace" consultancy making companies more aware of the potential implications of AIDS in the workplace.
  1 2 3 4 5

* An "AIDS in the workplace" consultancy assisting companies with their preventative AIDS measures. (policy/education)
  1 2 3 4 5

HIGHLY PRACTICAL	PRACTICAL	UNSURE	IMPRACTICAL	HIGHLY IMPRACTICAL
1	2	3	4	5

HERE ARE A NUMBER OF STATEMENTS WHICH PEOPLE HAVE MADE ABOUT **PREVENTATIVE AIDS EDUCATION PROGRAMMES.** HOW **PRACTICAL** DO YOU CONSIDER THEM TO BE FOR A **MANAGEMENT AIDS EDUCATION PROGRAMME** IN **YOUR** WORKPLACE?

* ongoing
  1 2 3 4 5

* presents facts, dispels myths
  1 2 3 4 5

* not too time consuming
  1 2 3 4 5

* during company time
  1 2 3 4 5

* tailored according to needs, attitudes, values, cultures of the audience.
  1 2 3 4 5

* aware of different education, socio - economic levels
  1 2 3 4 5

* communication through a multi - channel communication network
  1 2 3 4 5

* highlights medical facts
  1 2 3 4 5

* emphasise company policy
  1 2 3 4 5

* educate about safer sex
  1 2 3 4 5

* counter fear and anxiety
  1 2 3 4 5

* relevant to current social behaviour
  1 2 3 4 5

* provide information on company facilities regards AIDS prevention
  1 2 3 4 5

* provide pamphlets for employees to take home
  1 2 3 4 5

* be linked to relevant external bodies and community services
  1 2 3 4 5

HIGHLY PRACTICAL	PRACTICAL	UNSURE	IMPRACTICAL	HIGHLY IMPRACTICAL
1	2	3	4	5

HERE ARE A NUMBER OF STATEMENTS WHICH PEOPLE HAVE MADE ABOUT **PREVENTATIVE AIDS EDUCATION PROGRAMMES.** HOW **PRACTICAL** DO YOU CONSIDER THEM TO BE FOR AN **EMPLOYEE REPRESENTATIVE AIDS PROGRAMME** IN **YOUR** WORKPLACE?

* ongoing
  1 2 3 4 5

* presents facts, dispels myths
  1 2 3 4 5

* not too time consuming
  1 2 3 4 5

* during company time
  1 2 3 4 5

* tailored according to needs, attitudes, values, culture of the audience.
  1 2 3 4 5

* aware of different education, socio - economic levels
  1 2 3 4 5

* communication through a multi - channel communication network
  1 2 3 4 5

* highlights medical facts
  1 2 3 4 5

* emphasise company policy
  1 2 3 4 5

* educate about safer sex
  1 2 3 4 5

* counter fear and anxiety
  1 2 3 4 5

* relevant to current social behaviour
  1 2 3 4 5

* provide information on company facilities regards AIDS prevention
  1 2 3 4 5

* provide pamphlets for employees to take home
  1 2 3 4 5

* be linked to relevant external bodies and community services
  1 2 3 4 5

HIGHLY PRACTICAL	PRACTICAL	UNSURE	IMPRACTICAL	HIGHLY IMPRACTICAL
1	2	3	4	5

HERE ARE A NUMBER OF STATEMENTS WHICH PEOPLE HAVE MADE ABOUT **PREVENTATIVE AIDS EDUCATION PROGRAMMES.** HOW **PRACTICAL** DO YOU CONSIDER THEM TO BE FOR A **GENERAL EMPLOYEE AIDS EDUCATION PROGRAMME** IN **YOUR** WORKPLACE?

* ongoing
  1 2 3 4 5

* presents facts, dispels myths
  1 2 3 4 5

* not too time consuming
  1 2 3 4 5

* during company time
  1 2 3 4 5

* tailored according to needs, attitudes, values, cultures of the audience.
  1 2 3 4 5

* aware of different education, socio - economic levels
  1 2 3 4 5

* communication through a multi - channel communication network
  1 2 3 4 5

* highlight medical facts
  1 2 3 4 5

* emphasise company policy
  1 2 3 4 5

* educate about safer sex
  1 2 3 4 5

* counter fear and anxiety
  1 2 3 4 5

* relevant to current social behaviour
  1 2 3 4 5

* provide information on company facilities regards AIDS prevention
  1 2 3 4 5

* provide pamphlets for employees to take home
  1 2 3 4 5

* be linked to relevant external bodies and community services
  1 2 3 4 5

Question 48

PLEASE RANK **FIRST** IN ORDER OF **IMPORTANCE** , AND **SECOND** IN ORDER OF **"PRACTICALITY IN YOUR WORKPLACE"**, WHO YOU FEEL SHOULD BE INVOLVED IN AN **AIDS "TASK FORCE"** ?
(The task force would be responsible for the implementation of preventative AIDS provisions eg:policy, education)

a. top management

b. personnel/human resources

c. employee benefits

d. industrial relations

e. union/employee representatives

f. legal representatives

g. occupational health/medical profession

h. none of the above

RANK IN ORDER OF IMPORTANCE:

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

RANK IN ORDER OF "PRACTICALITY IN YOUR WORKPLACE":

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

Question 49

PLEASE RANK THE FOLLOWING STATEMENTS **FIRST** IN ORDER OF PREFERENCE, AND **SECOND** IN ORDER OF **"PRACTICALITY IN YOUR WORKPLACE":**

a. Employers are justified in excluding HIV-positive employees from benefit policies.

b. Through negotiation, a company - specific AIDS related benefits policy should be developed.

c. An HIV - positive applicant should be employed with limited benefits (specified by the insurance company).

d. HIV - positive employees should be treated in the same manner as all other employees.

RANK IN ORDER OF PREFERENCE:

☐ 1st ☐ 2nd ☐ 3rd

RANK IN ORDER OF PRACTICALITY:

☐ 1st ☐ 2nd ☐ 3rd

Question 50

PLEASE RANK **FIRST** IN ORDER OF **IMPORTANCE**, AND **SECOND** IN ORDER OF **"PRACTICALITY IN YOUR WORKPLACE"**, WHO YOU FEEL SHOULD BE INVOLVED IN THE **PREVENTATIVE AIDS EDUCATION?**

a. top management

b. management

c. personnel/ human resources

d. employee benefits

e. industrial relations

f. union/ employee representatives

g. concerned staff

h. occupational health/ medical profession

i. none of the above

RANK IN ORDER OF IMPORTANCE:

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

RANK IN ORDER OF "PRACTICALITY IN YOUR WORKPLACE":

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

APPENEDIX B

WHO/GPA/INF/88.7 Rev.
Original: English
Distr.: General

GLOBAL PROGRAMME ON AIDS

STATEMENT FROM THE CONSULTATION ON AIDS AND THE WORKPLACE

GENEVA
27–29 JUNE 1988

WORLD HEALTH ORGANIZATION
IN ASSOCIATION WITH
INTERNATIONAL LABOUR OFFICE

Consultation on AIDS and the Workplace

A Consultation on AIDS and the Workplace was convened in Geneva by the World Health Organization's Global Programme on AIDS (GPA) in association with WHO's Office of Occupational Health and the International Labour Office (ILO) from 27-29 June 1988. Thirty-six participants from 18 countries attended including representatives of government, union, business, public health, medical, legal and health education.

Three themes were addressed by the Consultation:

- Risk factors associated with HIV infection in the workplace;
- Responses by business and workers to HIV/AIDS; and
- Use of the workplace for health education activities.

The Consultation developed the following consensus statement:

I. General statement

Infection with the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) represent an urgent worldwide problem with broad social, cultural, economic, political, ethical and legal dimensions and impact.

National and international AIDS prevention and control efforts have called upon the entire range of health and social services. In this process, in many countries, HIV/AIDS prevention and control problems and efforts have highlighted the weaknesses, inequities and imbalances in existing health and social systems. Therefore, in combating AIDS, an opportunity exists to re-examine and evaluate existing systems as well as assumptions and relationships.

Today there are 2.3 billion economically active people in the world. The workplace plays a central role in the lives of people everywhere. A consideration of HIV/AIDS and the workplace will strengthen the capacity to deal effectively with the problem of HIV/AIDS at the local, national and international levels.

In addition, concern about the spread of HIV/AIDS provides an opportunity to re-examine the workplace environment. It provides workers, employers and their organizations, and where appropriate, governmental agencies and other organizations, with an opportunity to create an atmosphere conducive to caring for and promoting the health of all workers. This may involve a range of issues and concerns, not only individual behaviour, but also addresses matters of collective responsibility. It provides an opportunity to re-examine working relationships in a way that promotes human rights and dignity, ensures freedom from discrimination and stigmatization, and improves working practices and procedures.

II. Introduction

Epidemiological studies from throughout the world have demonstrated that the human immunodeficiency virus (HIV) is transmitted in only 3 ways:

(a) through sexual intercourse (including semen donation);
(b) through blood (principally blood transfusions and non-sterile injection equipment; also includes organ or tissue transplant);
(c) from infected mother to infant (perinatal transmission).

There is no evidence to suggest that HIV transmission involves insects, food, water, sneezing, coughing, toilets, urine, swimming pools, sweat, tears, shared eating and drinking utensils or other items such as protective clothing or telephones. There is no evidence to suggest that HIV can be transmitted by casual, person-to-person contact in any setting.

HIV infection and AIDS (HIV/AIDS) are global problems. At any point in time, the majority of HIV-infected persons are healthy; over time, they may develop AIDS or other HIV-related conditions or they may remain healthy. It is estimated that approximately 90% of the 5-10 million HIV-infected persons worldwide are in the

economically productive age-group. Therefore, it is natural that questions are asked about the implications of HIV/AIDS for the workplace.

In the vast majority of occupations and occupational settings, work does not involve a risk of acquiring or transmitting HIV between workers, from worker to client, or from client to worker. This document deals with workers who are employed in these occupations. Another consultation to be organized by the WHO Global Programme on AIDS will consider those occupations or occupational situations, such as health workers, in which a recognized risk of acquiring or transmitting HIV may occur.

The purpose of this document is to provide guidance for those considering issues raised by HIV/AIDS and the workplace. Such consideration may involve review of existing health policies or development of new ones. This document focuses upon the basic principles and core components of policies regarding HIV/AIDS and the workplace.

By addressing the issues raised by HIV/AIDS and the workplace, workers, employers and governments will be able to contribute actively to local, national and international efforts to prevent and control AIDS, in accordance with WHO's Global AIDS Strategy.

III. Policy principles

Protection of the human rights and dignity of HIV-infected persons, including persons with AIDS, is essential to the prevention and control of HIV/AIDS. Workers with HIV infection who are healthy should be treated the same as any other worker. Workers with HIV-related illness, including AIDS, should be treated the same as any other worker with an illness.

Most people with HIV/AIDS want to continue working, which enhances their physical and mental well-being and they should be entitled to do so. They should be enabled to contribute their creativity and productivity in a supportive occupational setting.

The World Health Assembly resolution (WHA41.24) entitled, "Avoidance of discrimination in relation to HIV-infected people and people with AIDS" urges Member States:

"... (1) to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS ...;

(2) to protect the human rights and dignity of HIV-infected people and people with AIDS ... and to avoid discriminatory action against, and stigmatization of them in the provision of services, employment and travel;

(3) to ensure the confidentiality of HIV testing and to promote the availability of confidential counselling and other support services ..."

The approach taken to HIV/AIDS and the workplace must take into account the existing social and legal context, as well as national health policies and the Global AIDS Strategy.

IV. Policy development and implementation

Consistent policies and procedures should be developed at national and enterprise levels through consultations between workers, employers and their organizations, and where appropriate, governmental agencies and other organizations. It is recommended that such policies be developed and implemented before HIV-related questions arise in the workplace.

Policy development and implementation is a dynamic process, not a static event. Therefore, HIV/AIDS workplace policies should be:

(a) communicated to all concerned;
(b) continually reviewed in the light of epidemiological and other scientific information;
(c) monitored for their successful implementation;
(d) evaluated for their effectiveness.

V. Policy components

A. Persons applying for employment: Pre-employment HIV/AIDS screening as part of the assessment of fitness to work is unnecessary and should not be required. Screening of this kind refers to direct methods (HIV testing) or indirect methods (assessment of risk behaviours) or to questions about HIV tests already taken. Pre-employment HIV/AIDS screening for insurance or other purposes raises serious concerns about discrimination and merits close and further scrutiny.

B. Persons in employment:

1. **HIV/AIDS screening:** HIV/AIDS screening, whether direct (HIV testing), indirect (assessment of risk behaviours) or asking questions about tests already taken, should not be required.

2. **Confidentiality:** Confidentiality regarding all medical information, including HIV/AIDS status, must be maintained.

3. **Informing the employer:** There should be no obligation of the employee to inform the employer regarding his or her HIV/AIDS status.

4. **Protection of employee:** Persons in the workplace affected by, or perceived to be affected by HIV/AIDS, must be protected from stigmatization and discrimination by co-workers, unions, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.

5. **Access to services for employees:** Employees and their families should have access to information and educational programmes on HIV/AIDS, as well as to relevant counselling and appropriate referral.

6. **Benefits:** HIV-infected employees should not be discriminated against including access to and receipt of benefits from statutory social security programmes and occupationally related schemes.

7. **Reasonable changes in working arrangements:** HIV infection by itself is not associated with any limitation in fitness to work. If fitness to work is impaired by HIV-related illness, reasonable alternative working arrangements should be made.

8. **Continuation of employment relationship:** HIV infection is not a cause for termination of employment. As with many other illnesses, persons with HIV-related illnesses should be able to work as long as medically fit for available, appropriate work.

9. **First aid:** In any situation requiring first aid in the workplace, precautions need to be taken to reduce the risk of transmitting blood-borne infections, including hepatitis B. These standard precautions will be equally effective against HIV transmission.

APPENDIX C

RESOURCES IN CAPE TOWN FOR DEALING WITH HIV AND AIDS

COUNSELLING

NAME	ADDRESS	TEL. NO.	TIME	DESCRIPTION
GASA-6010	P O Box 6010 Roggebaai 8012	23-6826 Tuesday 17h00 to 22h00 24-hour telecall 21-5420 page no. 45452 from 08h00 to 18h00 page no. 45209 from 18h00 to 08h00 Sat & Sun		Gasa does telephone and face to face general counselling on all gay concerns, relationships, personal problems and also specializes in dealing with HIV infection and AIDS. Their counsellors see clients for two pre-test sessions. They have the facility to draw bloods for HIV testing and use pseudonyms to ensure confidentiality. Should someone be found to be HIV antibody positive, GASA sees the client for a minimum of 6 post-test counselling sessions.
Individual Counsellors:				
GORDON ISAACS		W: 650-3493		Further supportive counselling for peopl living with HIV/AIDS is also available. G facilitates access to "Body Positive", a social and support group for persons living with HIV/AIDS which is run under the auspices of ASET and is not an all-gay group.
MIKE DE VILLIERS		H: 44-9622		
GILL FUNNEL		H: 797-9630 (temporarily off the service unless client wishes to see a woman or in an emergency).		GASA-6010's services are free. Donations are accepted.
JOHN PEGGE		H: 47-3614		

NAME	ADDRESS	TEL.NO.	TIME	DESCRIPTION
ATICC (AIDS Training Information and Counselling Centre) TRISH VAN DER VELDE CARROLL JACOBS MACHTELD VAN LENNEP MARTINE VAN DER WESTHUYSEN	Civic Centre 12 Hertzog Blvd. Cape Town 8001	210-2682 210-3400	08:00-16:45 Mon. to Fri.	ATICC has the facility for taking blood. use pseudonyms to ensure confidential ATICC provides pre- and post-test couns ling. ATICC is involved with training profess als in AIDS prevention and counselling skills. Three-day training workshops are offere three times per month. A three-day counselling skills workshop is run in the last week of every month. Other one-day courses offered by arrang ment. ATICC also serves as an information service to the general public. ATICC will also be involved in a community outreach programme.
Cape Mental Health Society MRS TONY TICKTON, Director	22 Ivy Street Observatory 7925 Private Bag X7 Observatory 7935	47-9040		They provide short and long term support counselling. The individual's needs ar assessed first by the intake team. The services are free and are open to all racial groups.

NAME	ADDRESS	TEL. NO.	TIME	DESCRIPTION
Planned Parenthood Association LINDA HILES	Unit 8A The Waverley Dane Street Mowbray 7700	685-3017		PPA is primarily involved with education in human sexuality. Planned Parenthood have an AIDS education unit.

COUNSELLING, TESTING AND MEDICAL TREATMENT

SOMERSET HOSPITAL DR F SPRACKLEN Chief Clinical Physician SEAN JACOBS, Clinical Psychologist, AIDS team co-ordinator SISTER FIELDER : all appointments for testing etc., to be made through her.	Beach Road Green Point	21-3311 Ext. 202 & 203	The clinic is open 07:30-16:30 Mon. to Fri The clinical psychologist is available 08:30-12;30 on Tuesdays and Wednesdays but can arrange for other times if necessary	The outpatient clinic on HIV/AIDS is conducted by a multi-disciplinary team comprising a psychiatrist,clinical psychologist, social worker, chaplain and medical staff. Both pre- and post-test counselling is offered as well as supportive counselling or psychotherapy, depending on the need of the individual. There is also a patient group. Somerset specializes in the medical treatment of HIV and AIDS. Testing of blood is under code to ensure confidentiality. There are no costs involved for the treatment of HIV related illness.

NAME	ADDRESS	TEL. NO.	TIME	DESCRIPTION
		CITY COUNCIL CLINICS		
Chapel Street DR MASEY	Balfour Road Woodstock 7925	210-2184	08:30-16:00 The clinic is open for HIV testing Mon. to Fri	The Chapel Street clinic offers pre- and post-test counselling. Actual AIDS cases are referred to Somerset for medical treatment.
Wynberg Clinic	Lower Church St Wynberg 7800	7975190/1		Pre- and post-test counselling are offered before and after HIV testing.
Silvertown Clinic	Petunia Street Silvertown 7764	637-1293/4		Pre- and post-test counselling are offered before and after HIV testing.
ASET (AIDS Support and Education Trust)	P O Box 6010 Roggebaai 8012	47-8400		Body Positive - support and social group for persons living with HIV. Access via counsellors and/or B.P. support team. Publishes monthly newsletters.
BODY POSITIVE Chairman: RICK		H: 44-4050 W: 92-1040 ext 2665		
BEFRIENDERS Co-ordinator: Stephen Leeder		H: 24-6438 W: 418-5050		Befrienders ("Buddies") of persons living with AIDS. The befrienders consist of men and women who have undergone training and are assigned to persons living with AIDS on a common interest basis.
COUNSELLORS	GORDON ISAACS JOHN PEGGE MIKE DE VILLERS	W: 650-3493 H: 47-3614 H: 44-9622		

APPENDIX D

Western Province AIDS Training,
Information and Counselling Centre

AIDS TICC
VIGS VIROS

Westelike Provinsie VIGS Inligting-,
Raadpleging- en Opleidingsentrum

This is to certify that

Hiermee word gesertifiseer dat

Tracey Pickholz

has successfully completed the three day workshop in

die driedaagse opleidingskursus suksesvol voltooi het in

AIDS INFORMATION AND PREVENTION

VIGS-INLIGTING EN VOORKOMING

SIGNED

GETEKEN

1990-02-01

DATE

DATUM

Ground Floor, Podium Block
Civic Centre
12 Hertzog Boulevard
Foreshore, Cape Town
Tel: (021) 210-3400
Fax: (021) 251-497
Telex: 52 0966 CEECT SA

Grondverdieping, Podiumblok
Burgersentrum
Hertzog-boulevard 12
Strandgebied, Kaapstad
Tel: (021) 210-3400
Faks: (021) 251-497
Teleks: 52 0966 CEECT SA

AIDS care, not AIDS scare